Confidential Report
to the Attorney General of British Columbia

from the Child and Youth Officer
for British Columbia

on the Continued Placement of Children in the Home
Where the Nuu-Chah-Nulth Child Died

September 29, 2006

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September 29, 2006

Honourable Wally Oppal, QC
Attorney General of British Columbia

I am pleased to transmit to you under Section 6 of the *Office for Children and Youth Act* the confidential report of my investigation of the circumstances surrounding the continued placement of children in the Port Alberni home in which the Nuu-chah-nulth child died on September 4, 2002.

I had broad terms of reference to investigate the circumstances surrounding the continued placement of children in this home over a seven month time period. In accordance with my mandate, this is the report of the results of that investigation.

This investigation was conducted, as was my previous investigation relating to the Director's case review, by reviewing relevant documentation and examining numerous witnesses, followed by a process for notice and written representations. In that process, individuals and organizations that might be adversely affected by the report were notified and given an opportunity to receive and respond in writing to confidential notice materials. The notice materials in each case included a document describing the substance of information reflecting on the recipient that might be included in the report. The responses received were carefully considered and incorporated as appropriate into this report.

For the investigation and the report, the significant public interest served by this process and the interests of individuals and organizations that were potentially adversely affected by its results, were addressed through the observance of guiding principles of fairness, thoroughness and efficiency. Mindful of your stated intention to make the report public subject to privacy requirements, the formulation of the report itself was additionally guided by principles of candour, accessibility to the public and, to the limited extent that the circumstances have enabled it to be protected, personal privacy.

The report does not refer to individuals by name, however most are readily identifiable by association with their official positions, the public notoriety of this case, or information about their lives or involvement that is necessarily in the report. I have excluded some very sensitive personal information that is not necessary to the completeness and public

interest purposes of the report. I am satisfied that those exclusions do not undermine the integrity of my report under the *Office for Children and Youth Act*.

I consider myself obliged to inform you that the Coroners Service and the local Coroner who handled the child's death have argued that my terms of reference mean that this report is to be a narrative of the events, times and circumstances surrounding the continued placement of children in the home. They have acknowledged that this narrative could include the reasoning behind the actions of any party, but have maintained that comments indicating any sort of fault or blame for those actions are precluded. They have submitted that I am, even more importantly, precluded from making any finding or suggestion that a party to the events referred to in the report was guilty of any illegal action or breach of any statute. They have objected to my report expressing any "value judgment" concerning the events and actions that were investigated.

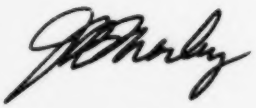
On these premises, the Coroners Service and the local Coroner have argued that my report may not include commentary or suggestions that evaluate the efficacy of the actions of the Coroners Service or the Coroner; reflect adversely on the Coroners Service's cooperation with other social agencies; reflect adversely on the veracity of the Coroner's statements; or reflect adversely on the Coroner's competence or compliance with Section 14 of the *Child, Family and Community Service Act*.

I do not agree that evaluative content is not intended or permitted in a report of the results of an investigation under Section 6 of the *Office for Children and Youth Act* or in this report in particular. Investigation is a process of observation or study by close examination and systematic inquiry. The results are the fruits of the investigation in the form of the consequences and conclusions of that systematic examination. An investigation of the circumstances surrounding an event or events, in this case the continued placement of children in this home, necessarily engages heavily in gathering, examining and making observations about factual information. The results of an investigation inevitably have an evaluative nature, whether or not expressed as findings or judgments.

My report explains in plain terms how the circumstances surrounding the continued placement of children in this home were investigated, assessed, tested and verified. Where certainty was not possible or there was apparently conflicting information in a critical area, the results of the investigation have been described on the basis of what most likely happened. The results of my investigation are not and cannot be findings of civil or criminal responsibility.

This process should be a means of learning about and improving services that affect children, youth and families. In this report I tell what the investigation found happened; I make observations about the systemic implications of what happened; and I provide my advice to government about how the system can improve its response to child deaths in a way that reduces the risk of harm to living children. I have avoided making unnecessary negative or critical statements about individuals or organizations. In order to fully report on what happened, however, I have considered it necessary to make some observations that may be viewed as negative or critical of what was done or not done in relation to the circumstances surrounding the continued placement of children in the home.

I believe that my approach to interpreting my terms of reference and Section 6 of the *Office for Children and Youth Act* is a proper one and that it is in harmony with, and indeed also supported by, the Child and Youth Officer's general functions in Section 3.



Jane Morley, QC
Child and Youth Officer for British Columbia

Acknowledgements

This investigation proved much more challenging and complicated than anything I had anticipated when the terms of reference were given or the work began. I could not have done it alone. It required the dedication of everyone involved. Most notably I want to express my gratitude for the enormous effort of my legal counsel, Susan Ross. It was Susan Ross, working closely with Associate Child and Youth Officer Jeannie MacPherson, who conducted the examinations of the 31 witnesses. Together they spent many hours reviewing files and making document inquiries, in some cases conducting preliminary interviews, then preparing for, carrying out and following up on the examinations. Throughout the writing of my report, I was advised extensively by Susan on the results of the investigation. Her counsel on the legal and procedural issues that arise in an investigation of this sort has been invaluable.

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PART 1: INTRODUCTION

1.1 About This Report

The story of the 19-month-old Nuu-chah-nulth child who was killed by her male caregiver in her caregivers' home in Port Alberni on September 4, 2002 is now well known. This report tells another story. It is the story of her brother and the caregivers' children, who were left in the home for months after the child's death despite the fact that within a week of her death government authorities were aware of medical evidence that raised suspicions that her death might have been a homicide.

This report sets out the results of an investigation I initiated because I was concerned that the legitimate questions that had been raised publicly about the continued placement of the children were unlikely to be answered by the other processes underway related to the child's death.

On November 10, 2005, the Attorney General of British Columbia formally requested, under Sections 6 of the *Office for Children and Youth Act*, that I undertake an investigation and report to him on the circumstances surrounding the continued placement, after the child's death, of her brother, and any other child in the home where she was living at the time of her death.

The investigation and report process under Section 6 of the *Office for Children and Youth Act* is not a public inquiry. The results of the investigation must be compiled in a confidential report to the Attorney General, who may decide whether or not that report should be made public. The Attorney General has stated that he intends to make the report public subject to privacy requirements, and the report is therefore written on the assumption that it will become a public document.

The report is divided into three parts:

- the introduction – about the report, the investigation, the records, and the key people and organizations in the story
- the narrative – what happened, with necessary contextual and background information
- my observations and advice arising from the narrative.

The story begins on September 9, 2002, when an autopsy of the child was completed by the pathologist in the presence of police, and an interim autopsy report was sent to the Port Alberni coroner.[1] On this day the Coroner and police learned that the child's injuries and death were not consistent with the male caregiver's explanation that she had fallen down a few steps. How, despite that, the children came to be left in the home (in the case of the brother until early February and of the caregivers' children until late March 2003) cannot be fully understood without reference to what protection workers knew or what information was available to them on September 9, and how that changed over time; the narrative sets out that progression.

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[1] Throughout this report, "the Coroner" is used to mean the local Port Alberni coroner. When the provincial coroner's operation is referred to, "the Coroners Service" is used.

The narrative does not use the names of the children, family members or officials, although they are all readily identifiable by the context. The child who died's name is not used because family members and the Nuu-chah-nulth have asked that it not be used out of respect for her and for their culture.

Other names have not been used to temper the impact of the publication of the report on the privacy of the family, in particular, and to accentuate that the purpose of this investigation and report is not to hold individuals accountable, but rather to learn, from what happened in a particular case, lessons of general applicability about how the system's response can be improved in the future. While individuals did and do make a difference, it is my belief that a similar story could happen tomorrow with different individuals involved unless we take steps to change the system. In medieval "Everyman" morality plays, players are not given proper names (e.g., a character would be called "The Traveller" rather than "John Smith"), because the messages of the play have universal application. The same can be said of the story set out in the second part of this report.

To make it easier to understand the key people involved in the story and their familial and organizational relationships, both lists and charts introducing the key family members, organizations and officials are provided at the end of Part 1.

The amount of detail in the story can be overwhelming, especially for those not intimately knowledgeable about child protection policy and practice. To assist the reader, an effort has been made to tell the story chronologically, with the exception that after the initial events of the autopsy are described, the narrative goes back in time to capture the prior involvement and knowledge of child protection workers before the beginning of the story on September 9. In addition, the narrative is interspersed with background information to assist the reader in understanding the events as they unfold.

The report is divided into five time periods, each with its own focus, although threads of the key themes of the story run throughout. The periods and their particular focuses are:

- September 9–10, 2002 – the autopsy, its completion and the communication of its results to the Coroner in the interim autopsy report and to the Port Alberni police orally.
- September 10–18, 2002 – the communications, or lack thereof, of information about the interim autopsy report among the Coroner, the police, Ministry of Children and Family Development (MCFD) and Usma.
- September 17–November 8, 2002 – the investigation and assessment work done by the district MCFD and Usma leading to their respective decisions not to remove the children from the home.
- November 9, 2002–January 15, 2003 – waiting for the final autopsy report
- January 16–February 3, 2003 – the communication, or lack thereof, of the final autopsy report's finding of "battered child syndrome" as the cause of death and Usma's decision to remove the brother from the home.
- January 27–June 13, 2003 – the district MCFD's consideration of whether to remove the caregivers' children from the home.

1.2 About the Investigation

The investigation got underway after the conclusion of the inquest into the child's death under the *Coroners Act* in February 2006.

The investigation reviewed extensive MCFD and Usma records relating to the child, her brother, their parents, the caregivers, and the immediate and extended family of all of them. The MCFD re c o rds were from the district office in Port Alberni, the regional office in Nanaimo (these included historical family service records from when the families or children involved were living in the Victoria area) and its headquarters offices in Victoria. They included printed records from MIS SWS[2] and, such as they were available, other electronic and email records at all MCFD levels. The Usma records were mainly printed files that included records from the Usma TRIBES electronic data management system for social work files.

The investigation also had the benefit of records from the Royal Canadian Mounted Police (RCMP) detachment in Port Alberni, the Coroners Service, the Health Assessment and Resources for Children (HARC) unit in Victoria, and two Port Alberni physicians who were consulted by protection workers.

Witnesses from all of these sources – 31 in all – were examined over many hours. Interested family members were also invited to provide input and meet with the investigation, and some chose to do so.

Before this report was concluded, individuals and organizations that might be adversely affected by it were notified and given an opportunity to make representations to the investigation. All representations received were carefully considered in the finalization of the report.

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[2] MIS SWS is the MCFD electronic data management system for social work files. It is commonly referred to by most people as SWS MIS.

1.3 About the Records

There were no detectable gaps in the district MCFD or Usma records that gave serious concern about being able to adequately conduct the investigation.

The records received from the police, Coroners Service, and two Port Alberni physicians were indispensable in piecing together what happened. They too were not detectably incomplete in any serious way for the investigation.

The Usma protection workers keep detailed file notes using the TRIBES data management system. Each note was dated and the writer was identified by name. Summary sheets were printed off on the file every three months. The practice of Usma protection workers was to destroy handwritten notes after entry as TRIBES contact notes. This was reflected in the state of the Usma case files, except for one set of handwritten "sticky notes" of details of the child's injuries, which the Usma Supervisor learned about from the Coroner on October 31, on her understanding that she could not record or disclose it. The circumstances of the creation of these "sticky notes" will be discussed further in the narrative.

Record-keeping for the district MCFD case files during the period under investigation was generally less comprehensive than for the Usma case files. The file notes recorded on MIS SWS were less detailed, they were sometimes undated, and the writer was often not noted. Initiating information about the suspiciousness of the child's death was not recorded for Intake 12 (opened shortly after the child's death) because the MCFD District Supervisor and the Aboriginal Services Practice Analyst believed the Coroner required them not to disclose that information to Usma protection workers, who could be expected to have access to MCFD MIS SWS intake records. This will also be discussed further in the narrative.

The completeness of the MCFD headquarters records (electronic and paper) was questionable.

Several MCFD headquarters officials involved in the case kept "black books" with notes of their daily activities on the job. This is a common and mostly uncontrolled practice in the higher echelons of the provincial government. The "black books" of one official were still in her control at MCFD, so that, even though their content was not integrated into MCFD electronic records or paper files, they were available to the investigation and to assist her memory of events relating to the case.

The Deputy Director, Aboriginal Services, who retired in March 2004, and the Aboriginal Services Practice Analyst, who left government in 2003, had properly left their "black books" with MCFD. These could not be found for the investigation and likely contained relevant information for the investigation, particularly the Practice Analyst's notes concerning discussions about information sharing with Usma, and any notes the Deputy Director, Aboriginal Services made of her October 28 telephone conversation with Usma. Since content from the "black books" was not integrated into MCFD electronic or paper files, the loss of the "black books" meant that the information in them was not available to the investigation.

The investigation was told that according to government policy, computer system electronic backups are regularly made for security of information and emergency system recovery purposes. Computer system backup records are required only for a limited period of time to ensure access to essential information in case of system failure. It is the responsibility of the user to save any required electronic mail.

Electronic files (depending on whether they exist for one day or one month) were backed up and retained for 60 days to two years. Email box backups were available only back to 2004. Because the investigation was into events that happened more than three years ago, relevant MCFD electronic files were available only if they had been printed and retained as locatable paper files.

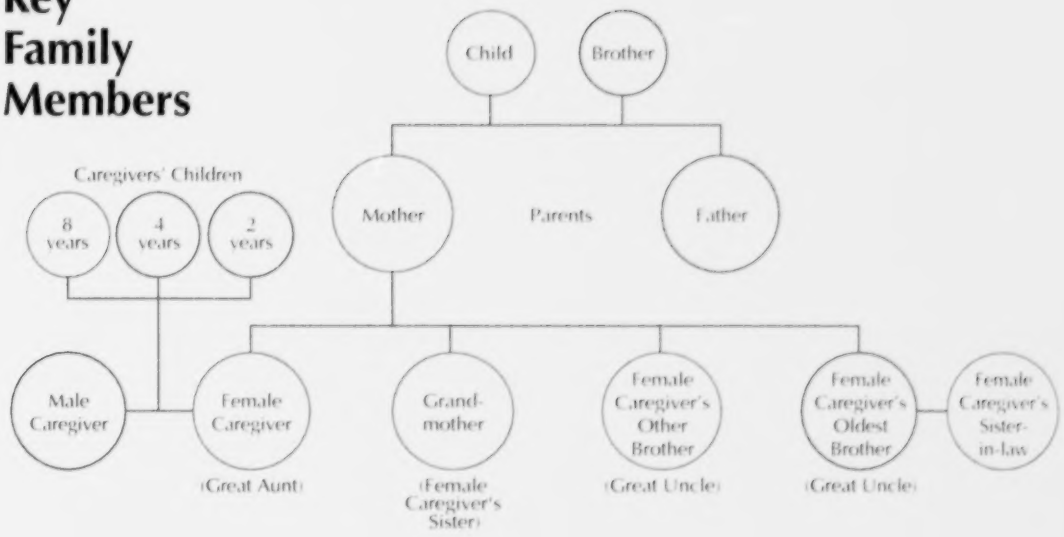
The Deputy Director, Aboriginal Services' government electronic appointment calendar, which she believed might help her recall of events, was not recoverable and therefore not available to the investigation.

Officials at MCFD headquarters who were most closely involved with the case (preparing briefing notes, making telephone calls and gathering source information) did not think the paper files were complete. Other indicators supported this:

- The paper files were not methodically organized and had gaps.
- The text boxes in the Fatality Tracking System (FTS) database had unlimited character capacity. However, all that was on the paper files was a September 6, 2002 one-page FTS printout; a December 5, 2005 one-page FTS printout containing the same information, plus a 2004 note (of the assignment of the file to a new practice analyst over a year after the previous practice analyst had left the government) and a 2005 note of the conviction of the male caregiver; and two one-page case file printouts with information as at September 6, 2002.
- The Aboriginal Services Practice Analyst used a personal "Palm Pilot" on which he recorded information and downloaded it onto an MCFD electronic platform. No data of that nature was on the paper files.
- The paper files did not contain emails from the drive of the Aboriginal Services Practice Analyst.
- The paper files contained neat and dated handwritten notes of several September 2002 telephone calls by the Aboriginal Services Practice Analyst, but no records of other telephone calls he participated in, at least two of which (on October 30 and 31) were known to be important calls at the time.

It was not part of this investigation to scrutinize government record retention policy or practice, except to the extent that a policy or practice, or failure to follow it, affected the ability to conduct the investigation. Of the sources of relevant information for the investigation, MCFD headquarters' involvement in the case was the least completely recorded and retained. This did impair the investigation, particularly with respect to the involvement of Aboriginal Services and other MCFD headquarters managers.

Key Family Members



The child and her brother have a large extended family. The only family members identified below are those referred to in the narrative. With three exceptions they are identified by their relationship to the child and the brother. They are:

The child: the Nuu-chah-nulth child who died on September 4, 2002, at the hands of her male caregiver.

The brother: the brother of the child who died, who was 3 years old at the time of her death.

The parents: the mother and father of the child and the brother.

The grandmother: the maternal grandmother of the child and the brother, and the sister of the female caregiver.

The female caregiver: the great aunt of the child and the brother, who had the care of them under a kith and kin agreement.

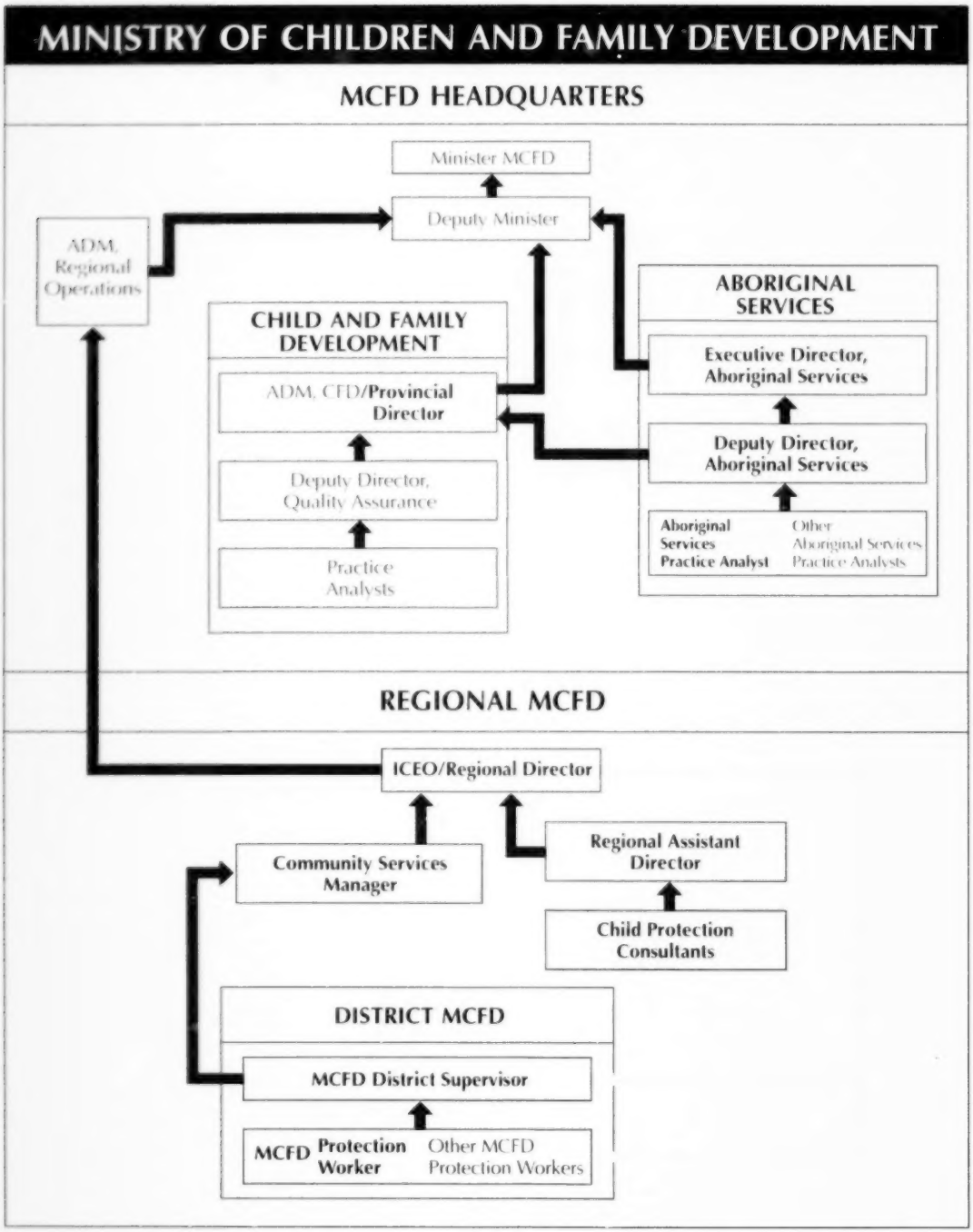
The male caregiver: the husband of the female caregiver who had the care of the child and the brother under a kith and kin agreement, and who killed the child.

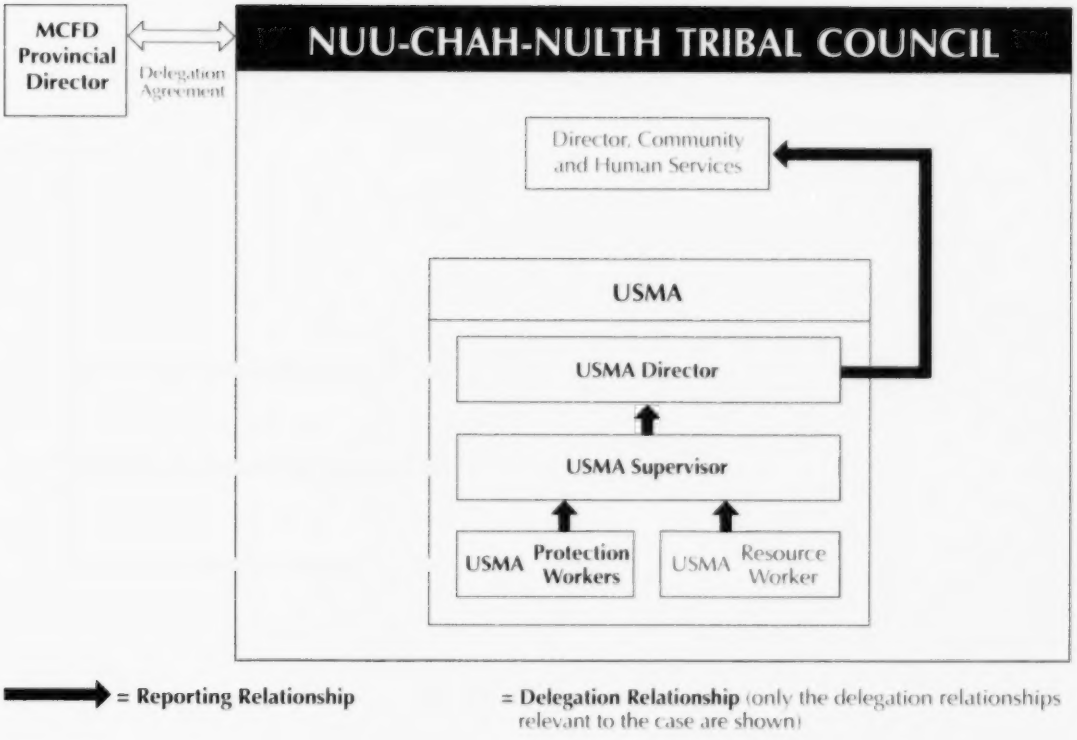
The caregivers' children: the caregivers' three children, ages 8, 4 and 2.

The female caregiver's sister-in-law: the wife of the female caregiver's oldest brother. She was employed by Usma as a fully delegated child protection social worker under the CFCSA.

The female caregiver's oldest brother: the female caregiver's brother, who was the oldest male child in his family and the great-uncle of the child and the brother.

The female caregiver's other brother: another brother of the female caregiver and the great-uncle of the child and the brother.


MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
MCFD HEADQUARTERS
Minister MCFD
Deputy Minister
ADM, Regional Operations
CHILD AND FAMILY DEVELOPMENT
ADM, CFD/Provincial Director
Deputy Director, Quality Assurance
Practice Analysts
ABORIGINAL SERVICES
Executive Director, Aboriginal Services
Deputy Director, Aboriginal Services
Aboriginal Services Practice Analyst
Other Aboriginal Services Practice Analysts
REGIONAL MCFD
ICEO/Regional Director
Community Services Manager
Regional Assistant Director
Child Protection Consultants
DISTRICT MCFD
MCFD District Supervisor
MCFD Protection Worker
Other MCFD Protection Workers
= Reporting Relationship
= Delegation Relationship (only the delegation relationships relevant to the case are shown)


MCFD
Provincial
Director
Delegation
Agreement
NUU-CHAH-NULTH TRIBAL COUNCIL
Director, Community
and Human Services
USMA
USMA Director
USMA Supervisor
USMA Protection
Workers
USMA Resource
Worker
= Reporting Relationship
= Delegation Relationship (only the delegation relationships
relevant to the case are shown)

Key officials – Ministry of Children and Family Development

MCFD headquarters: the provincial operations of the Ministry of Children and Family Development (MCFD) in Victoria.

Provincial Director: the designated director under the *Child, Family and Community Service Act* (CFCSA) with statutory responsibility for protection and guardianship of Aboriginal children for whom Aboriginal agencies had delegated responsibility under the CFCSA. He reported to the Deputy Minister.

Aboriginal Services: the part of the MCFD headquarters operation responsible for, among other things, practice support to Aboriginal delegated agencies.

Executive Director, Aboriginal Services: the senior manager in Aboriginal Services, and a member of the provincial executive. He reported to the Deputy Minister.

Deputy Director, Aboriginal Services: the provincial Deputy Director under the CFCSA and the individual with responsibility for supervising the practice analysts in Aboriginal Services. She had a dual reporting relationship to the Provincial Director and to the Executive Director, Aboriginal Services.

Aboriginal Services Practice Analyst: the practice analyst in Aboriginal Services who had particular responsibility to provide practice support for Usma. Aboriginal Services also had other practice analysts and they all reported to the Deputy Director, Aboriginal Services.

Regional MCFD: the Vancouver Island region of MCFD operation.

ICEO/Regional Director: the Regional MCFD Interim Chief Executive Officer (ICEO) who at the time of the story was the designated director under the CFCSA with statutory responsibility for protection and guardianship of children within the Vancouver Island region of MCFD. She was designated director by the Minister of Children and Family Development and in her capacity as ICEO reported to the Deputy Minister through the Assistant Deputy Minister, Regional Operations.

Regional Assistant Director: the senior manager with the day-to-day responsibilities related to the statutory role of the Regional Director. He reported to the ICEO/Regional Director.

Community Services Manager: the senior manager responsible for the district MCFD operations in a geographical area of the Vancouver Island region that includes Port Alberni. He reported to the Regional Director in her capacity as Interim Chief Executive Officer.

Child Protection Consultants: the MCFD employees with child protection experience who provide clinical consultation and specialized resources to social workers and team leaders dealing with serious, complex, potentially contentious child maltreatment cases. There were four child protection consultants in the Vancouver Island region, and they reported to the Regional Assistant Director.

District MCFD: the district office of MCFD in Port Alberni.

MCFD District Supervisor: the supervisor and team leader of the MCFD district office's eleven social workers with responsibility for intake, assessment and family services. He reported to the Community Services Manager and had delegated responsibility, from the regional director, under the CFCSA.

MCFD Protection Worker: the front line social worker in the MCFD district office assigned to this case. The district office also had other protection workers. They all reported to the MCFD District Supervisor and had delegated responsibility, from the regional director, under the CFCSA.

Key officials – Usma

Usma: the Usma Nuu-chah-nulth Community and Human Services; the family and child service program of the Nuu-chah-nulth Tribal Council (NTC). Usma provided services for children residing on Nuu-chah-nulth reserve communities on the west coast of Vancouver Island.

Usma Director: the manager of Usma. She was an NTC employee and reported to the Director of Nuu-chah-nulth Community and Human Services. She had delegated authority, from the provincial director, under the CFCSA.

Usma Supervisor: the casework supervisor of Usma. She was an NTC employee and reported to the Usma Director. She had delegated authority, from the provincial director, under the CFCSA.

Usma Protection Workers: the two Usma protection workers assigned to this case. They were NTC employees and reported to the Usma supervisor. They had delegated authority, from the provincial director, under the CFCSA.

Key officials – Other

Coroner: the Port Alberni coroner with the jurisdiction under the *Coroners Act* to investigate the cause of the death of the child.

Police Officer: the Port Alberni RCMP officer assigned to this case.

Family Physician: the Port Alberni family physician for the caregivers' family and the brother of the child who died.

Attending Pediatrician: the pediatrician who saw the child in emergency on September 4 and assessed her brother on November 7.

PART 2: THE STORY OF THE CONTINUED PLACEMENT

This story really begins on September 9, 2002, five days after the Nuu-chah-nulth child died in Port Alberni. On that day, or shortly thereafter, government authorities (the coroner, the police and child welfare authorities) were aware of medical evidence that raised suspicions about the explanation given for the child's injuries at the time of her death.

On September 9, 2002, four children remained living in the home in Port Alberni where the child had died. It was the home of the child's mother's maternal aunt (the female caregiver) and of her husband, the male caregiver. The male caregiver was eventually charged with manslaughter in the death of the child. In October 2004 he pled guilty and was sentenced to ten years imprisonment.

The four children remaining in the home after the child's death were the child's three-year-old brother, and the three children of the caregivers (eight- and four-year-old girls and a two-year-old boy). The brother had been placed in the caregivers' home with his sister (the child who died) under a "kith and kin" agreement facilitated by Usma, a family and child services agency of the Nuu-chah-nulth Tribal Council (NTC). This story is about how these children came to be left in that home, in the case of the brother until the beginning of February 2003, and in the case of the other children, in their parents' custody until the end of March 2003.

2.1 September 9–10, 2002: The Autopsy, the Interim Autopsy Report and Its Communication to the Coroner and Port Alberni Police

On September 9 the pathologist, in the presence of police, completed the autopsy on the child's body that he had started three days earlier. On that day he sent an interim autopsy report to the local Coroner in Port Alberni. The next day the Port Alberni Police Officer assigned to the case was informed of the detailed contents of the autopsy report. The interim autopsy report revealed injuries that were inconsistent with the male caregiver's explanation of the injuries.

September 4: The male caregiver's explanation of the injuries

At the time of death, the child's body showed no obvious external signs of abuse. The male caregiver, who called 911, had been at home alone with the children. (The female caregiver and the couple's eight-year-old daughter were at the grocery store.) When the emergency responders and police arrived at the home, they found the child lying near the bottom of a carpeted circular staircase. The male caregiver told them that the three-year-old brother had pushed his 19-month-old sister down four or five steps.

On hearing this story, the Pediatrician who attended at the hospital had thought it strange that the child could have been fatally injured from a fall down five steps and wondered whether other circumstances were involved (natural or untoward, he did not know). He understood there would be an autopsy to determine the cause of death, including the possibility of an otherwise innocuous fall causing the child to bleed into an undetected brain tumour or the presence of some other medical condition.

The Coroner arranged for a pathologist to do an autopsy at BC Children's Hospital in Vancouver to assist in his investigation into the cause of the death.

September 9: Pathologist completes autopsy in presence of Vancouver-based RCMP officers and writes interim autopsy report

On September 6, on seeing a full-body x-ray done of the child that revealed multiple rib fractures, the pathologist conducting the autopsy had decided to stop the autopsy to arrange for police presence.

On September 9, the autopsy was completed in the presence of two Vancouver-based RCMP officers.

On September 9, the pathologist wrote an interim autopsy report.

The interim autopsy report was a one-page form (also called a Coroners Service Form C) with handwritten particulars filled in and signed by the pathologist. "Pending Further Studies" was written after the heading "Apparent Cause of Death" and the gross findings describing the child's injuries read as follows:

1. Evidence of head trauma, including scalp contusions, subdural hemorrhage (small volume) and small foci of the subarachnoid hemorrhage. No skull factures. Brain, spinal cord and eyes retained for further examination after fixation.
2. Evidence of blunt thoracoabdominal trauma, including:
   a) bilateral nondisplaced lateral rib fractures – some with callus formation
   b) mesenteric and retroperitoneal lacerations with hemoperitoneum (45 ml)
   c) subcapsular contusions and small lacerations of liver
   d) small epicardial contusion of posterior right atrium
3. No evidence of significant pre-existing natural disease.

September 9: Coroner receives interim autopsy report

The local Coroner in Port Alberni, who had attended at the hospital on the day the child died, received the interim autopsy report on September 9.

Background: The Coroners Service of British Columbia

The coroner's role under the *Coroners Act* is to investigate and inquire into unnatural, unexpected, unexplained or unattended deaths. The coroner must determine the identity of the deceased and how, when, where and by what means the deceased died. These findings are usually made by the coroner alone after a non-public inquiry process, or less frequently by a jury in a public inquest process presided over by a coroner.

The Chief Coroner for the province, regional coroners and local coroners are appointed under the *Coroners Act*. The Chief Coroner supervises, directs and controls all coroners in the performance of their duties. A regional coroner has, subject to the direction of the Chief Coroner, general supervision of the coroners in his region. A local coroner has, subject to the authority of the Chief Coroner and regional coroner, control and direction of the administration of the coroner's courts in his area. The Attorney General of British Columbia also has various original, supervisory and oversight powers under the *Coroners Act*.

Some jurisdictions appoint only doctors as coroners, but British Columbia has followed the system of appointing coroners from all walks of life. The criteria has been to select people of good repute in their community, who have demonstrated common sense, a balanced approach to life generally and an ability to meet challenges. They may or may not have specialized professional, trade or business training. If they need help to understand the dynamics of any part of case, they may hire whatever expertise is required, including forensic pathologists to assist in determining the medical cause of death.

A coroner may require a post-mortem medical examination of the deceased (an autopsy). This is done by a qualified pathologist and typically generates an interim autopsy report pending toxicology results, followed by a final autopsy report, which becomes the authoritative report of the death.

Note: Unless otherwise indicated in this report, "the Coroner" refers to the local coroner in Port Alberni who investigated the death of the child, and "Coroners Service" refers to the province-wide system that is overseen by the Chief Coroner.

September 10: Port Alberni RCMP receive information about autopsy

The Port Alberni RCMP officer assigned to the case was given information on September 10 about the autopsy in separate telephone calls from the pathologist and one of the attending police officers. She recorded what the pathologist told her about the child's injuries, as follows:

- has not determined cause of death
- injuries found are not consistent with having fallen down a few steps
- abdominal & head injuries
- tearing of liver
- tearing of omentum – fatty tissue around bowel
- blood in abdomen
- rib fractures on both sides – some were older and healing – probably no more than a couple of weeks
- some bruising on head
- little bleeding in & around brain
- needs to be sure of circumstances surrounding the occurrence
- will have to do microscopic examination of the brain

The attending police officer provided similar information. For both calls, the Port Alberni Police Officer's records did not describe the child's injuries in the medical terminology used by the pathologist in the interim autopsy report.

Although the police were informed about the content of the report on September 10, and the Police Officer assigned to the case recalled reading the interim autopsy report showed to her during meetings she had with the Coroner in September, there was no copy of the report in the police file before January 22, 2003. (On January 22, 2003, the Coroner faxed a copy of the interim autopsy to the police in Port Alberni, at their request.)

MCFD and Usma do not receive copy of interim autopsy report

At no time (prior to late 2005 when the Coroners Service provided interested parties with disclosure materials for the February 2006 inquest into the child's death) did MCFD or Usma receive a copy of the interim autopsy report.

While a copy of the interim autopsy report was not given to MCFD or Usma, there were numerous communications by the Coroner and the police about the contents of the interim autopsy report in the days that followed its completion. These communications and the extent to which various aspects of the child welfare authority knew or ought to have known its contents is a key part of the story of the continued placement. Before picking up the thread of that part of the story, it is necessary to look back in time to understand Usma's involvement in this case, knowledge about the caregivers prior to the child's death, and immediate response to the death.

2.2 Looking Back: Usma's Involvement, Prior Knowledge and Immediate Response to the Child's Death

Background: Usma, the Nuu-chah-nulth child welfare program

Usma, the Nuu-chah-nulth child welfare program, began in the late 1970s as a response by community members and elders to increasing child apprehensions and lack of programs available for Nuu-chah-nulth communities to prevent child abuse and neglect. By 1985 the Nuu-chah-nulth Tribal Council (NTC) and the provincial Superintendent of Family and Child Services had signed an agreement for the delivery of family and child welfare services to members of Nuu-chah-nulth First Nations living on reserve. In 1989 Usma became British Columbia's first Aboriginal agency with full responsibility for child protection, the highest level of delegated social work authority under the *Child, Family and Community Service Act* (CFCSA).

Usma's office is in Port Alberni, a logging town on the Alberni inlet in the middle of Vancouver Island, with a population of just under 19,000. Most of the fourteen Nuu-chah-nulth bands under Usma's jurisdiction are located some distance from Port Alberni and some are very isolated. These features are significant considerations for service delivery by Usma.

Under a new agreement between the NTC, the Director under the CFCSA, and the federal government that runs from April 1, 2004 to March 31, 2009, the delivery of services to Nuu-chah-nulth families living off reserve is being gradually transferred from MCFD to Usma. The plan is for Usma to become responsible for providing family services and child protection for all Aboriginal people residing off reserve in the Alberni Valley.

Usma's previous involvement

Involvement of MCFD and Usma with the parents of the child and her brother went back to 1999. A number of reports had been made of protection concerns for the children in the care of their parents, when they were living both on and off reserve. Usma had responsibility for investigating those reports made when the children were residing on the reserve at Ahousaht, a village on Flores Island off the west coast of Vancouver Island.

From early 2002 Usma had been steadily involved with the family, and Usma Protection Workers had made several trips to Ahousaht, where they met with both of the parents, extended family members, community members and police. Efforts to address protection concerns purely through the delivery of family services and supports failed. Usma Protection Workers concluded that the children were in need of protection, and on July 31 Usma obtained an interim supervision court order under the CFCSA. The parents did not abide by the conditions set for them in the supervision order and it soon became apparent to Usma Protection Workers and concerned family members that further steps were needed for the safety of the children. Usma did a comprehensive risk assessment and developed a risk reduction plan.

In coming up with a risk reduction plan and in looking for a less intrusive measure than removing the children from their home, Usma Protection Workers conferred with the children's parents, the maternal grandmother and her sister (the female caregiver). Both the children's parents had spent time in the caregivers' home when they were themselves growing up. The parents had decided that they were willing to place their two children with the caregivers in Port Alberni where the caregivers were raising their own three young children.

In support of this plan to place the children in the home of the caregivers, Usma facilitated a kith and kin agreement in mid-August. A kith and kin agreement is a kinship care arrangement under Section 8 of the CFCSA that had only been implemented as a policy by MCFD in July 2002.[1]

Assessing suitability of kith and kin caregivers

By the time the child died on September 4, the Usma staff collectively knew, or thought they knew, a certain amount about the caregivers and the suitability of their home as a placement for the child and the brother. That knowledge came primarily from Usma's earlier contact with the mother's family members in the context of Usma's protection concerns about the child and her brother in their parents' care and the facilitation of the kith and kin agreement with the caregivers.

Usma Protection Workers knew the female caregiver, as she was an Usma family support worker. (Family support workers do not have delegated authority under the CFCSA and the female caregiver did not deliver any services in the case.)

Whatever their prior knowledge of the caregivers, Usma needed to go through a formal assessment of suitability process, which they did. MCFD's July 2002 Draft Practice Guideline for Section 8 "Kith and Kin" Agreements (Appendix A) described the process for assessing the suitability of the prospective caregivers' home as follows:

> You should:
> - conduct a prior contact check regarding the care provider(s)
> - conduct a criminal record check-please refer to appendices for acceptance criteria
> - obtain two letters of reference from relatives
>
> Note: A formal assessment of the care providers will not be conducted. The pre-agreement checks are intended to ensure that there are no known child protection concerns/issues with the care providers.

The kith and kin process for gathering information about potential risks with the placement was underway but had not been completed when the child died on September 4.

Knowledge of male caregiver's criminal record

On August 14 Usma Protection Workers requested a criminal record check for the female caregiver from her Usma personnel file. They received it the following week and it raised no concerns.

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[1] For a more extensive discussion of kith and kin agreements, see the Child and Youth Officer's report, *Heshook-ish Tsawalk: Towards a State of Healthy Interdependence in the Child Welfare System*.

On August 30 the male caregiver provided a signed consent to the release of his criminal record. Although Usma Protection Workers did not receive his criminal record check from police until early October, they nonetheless had significant independent knowledge about his criminal record when the kith and kin agreement went ahead in August.

Earlier in 2002 the Usma Director had read in the newspaper about the male caregiver being convicted of assaulting the female caregiver. The Usma Director had brought the matter to the attention of the Usma Supervisor for her to look into whether the female caregiver's domestic circumstances affected her ability to do her job as an Usma family support worker. By the time the kin and kin arrangement was being considered, the Usma Director understood that possible concerns about the spousal assault had been resolved.

Usma Protection Workers were also aware of that recent spousal assault conviction; however, after discussing the circumstances surrounding the offence with the female caregiver, they were satisfied that the incident was an isolated one that had happened away from the home and the couple's children.

A mid-August Usma file note of a call between the Usma Supervisor and the MCFD District Supervisor about funding for the kith and kin agreement recorded that she explained to him that she was aware that the male caregiver had a criminal record; to her knowledge it did not include anything that would prevent the kith and kin agreement; but she needed to wait for confirmation of that information.

Knowledge of caregivers' prior contact with child welfare authorities

The prior contact check identifies historical contacts with the child welfare system by matching searched names with the existence of particular types of files on MIS SWS (the MCFD electronic data management system for social work files). Because Usma did not have access to MIS SWS, the practice was for the MCFD district office to fax prior contact checks to Usma on request. On August 20 an Usma administrative support worker had telephoned the MCFD district office to request a prior contact check on the caregivers. MCFD administrative staff faxed Usma two pages, consisting of a cover sheet and a page of MIS SWS print-out. The print-out was incomplete, in that it did not disclose that there were family service intakes on the caregivers' parenting abilities relating to their own and relatives' children. (The error in the prior contact check on the caregivers was not detected, and corrected by MCFD with apologies, until September 26.)

In mid-August the Usma Supervisor contacted the MCFD District Supervisor about funding for the kith and kin agreement. Both were aware that Usma did not have funding for an out-of-care placement. The MCFD District Supervisor said that he would look to find a way for MCFD to fund the kith and kin agreement with the caregivers in Port Alberni.

The MCFD District Supervisor was about to start a two-week vacation. Before leaving, he alerted the MCFD Protection Worker who would be covering his desk that there might be a call from Usma about policy for the new kith and kin agreement provision in the CFCSA. The MCFD District Supervisor instructed the protection worker to hold off on any agreement about funding until he returned to deal with the matter. This MCFD Protection Worker remembered receiving a telephone call within days from someone from Usma, in which he relayed the MCFD District Supervisor's instructions and, as he spoke, typed in a MIS SWS name search on the female caregiver (a prior contact check). He told the Usma caller that the screen showed the existence of 11 prior family service intakes, which he considered alarming. The MCFD Protection Worker did not recall who the Usma caller was and there was no record of the call in the MCFD or Usma files.

He did not recall the caller asking for a faxed copy of the prior contact check screen showing the 11 intakes, and was sure that he would have immediately provided this had it been requested.

The Usma Supervisor and protection workers assigned to the case had no knowledge of this call, which they could be expected to have remembered and recorded in their file notes. Given the organized, dated and detailed contact notes on the Usma files and the overall candour of these witnesses, it is unlikely that they had any involvement with the call. It is also unlikely that the caller could have been the Usma Director. She had no recollection of the call and almost always left case-specific tasks to the Usma Supervisor, social workers or other staff. The MCFD Protection Worker's recollection was credible, even though the call was not recorded in MCFD files. If this telephone call happened, and it may well have, the caller was most likely not the Usma Supervisor, an USMA Protection Worker assigned to the case or the Usma Director. The investigation could not resolve this point further.

Had the prior contact check that MCFD provided in August been complete, Usma Protection Workers would have been alerted to the existence of the historical MCFD family service intakes on the caregivers and could have requested a print-out of the approximately forty pages of MIS SWS recorded information on those intakes. Those intakes included important information that was relevant to the appropriateness of the caregivers' home as a placement. As it turned out, Usma did not see the full MIS SWS print-outs on MCFD's historical intakes relating to the caregivers until September 24.

Knowledge from family references

The caregivers were responsible for getting two family references for the kith and kin placement. The reference check form was one-page with seven questions and on August 22 Usma received the first one from the female caregiver's eldest brother and his wife, the sister-in-law (who was also an Usma protection worker). Their responses to four of the questions were as follows:

> 3. What kind of person is the Applicant(s)? (Include here personality traits, interests, concerns, strengths and weaknesses)
>
> ...cultural, family-oriented, swimming cultural events. Strengths – both very giving & generous – home affections, belongings. Both have a hard time saying no they are both understanding this can be a weakness and are beginning to set boundaries.
>
> 4. What is the Reference's impressions of the applicant's marriage or close relationships?
>
> Both have worked hard & learnt from their past issues to make changes & therefore have a stronger & committed relationship with each other & people that are important in their lives.
>
> 6. What are the Reference's impressions of how each Applicant relates to his/her own children and other people's children?
>
> Very good. [Female caregiver's] sense of humour draws children to her. [Male caregiver's] knowledge of Culture is a great teaching tool he utilizes with children.
>
> 7. Does the Reference see any problem in placing a Child in Care in this home?
>
> After witnessing this couple's growth & commitment to each other, their children, & other family members, no! They are committed to the safety & wellbeing of children.

On August 26 the caregivers signed the kith and kin agreements (with the parents and with Usma), which had a three-month term from August 15 to November 15. By August 27 the interview with the mother had been completed for Usma's comprehensive risk assessment respecting her children. A high-risk rating was assigned for both children.

The second family reference on the caregivers was dated September 4 but Usma did not receive it until September 27.

Usma's conclusions prior to child's death

In summary, prior to the child's death and based on what they knew at that time, the Usma staff collectively had reached the conclusions that:

(a) the children were not safe in their parents' care where they had been neglected and may have been physically abused, particularly by their mother;

(b) the caregivers' home was safe and appropriate for children; and

(c) the kith and kin arrangement with the caregivers had the confidence and support of the children's parents and extended family.

Usma Director's role in immediate response to child's death

On September 4, the Usma Director received a telephone call at her home from the sister-in-law of the female caregiver, wife of the female caregiver's eldest brother. (Usma employed the female caregiver as a family support worker and the sister-in-law as a protection worker.) When the female caregiver, who had been alerted at the grocery store, returned home, she had telephoned her sister-in-law. The sister-in-law had come to the caregivers' home and once there had telephoned the Usma Director to report that there had been an accident and that the child was being taken to the hospital. The Usma Director said she would meet the family at the hospital.

Usma Director's kinship connections

The Usma Director herself had kinship connections with the caregivers and the child and her brother. A brother of the Usma Director, who has many siblings, was the long-time common-law spouse of the male caregiver's mother. The Usma Director also had a deceased close first cousin whom some members of her family had acknowledged, after his death, as the biological father of the male caregiver. The investigation also learned that the Usma Director was reputed to be, through the maternal side of their family, in a "grandmother" relationship to the child and her brother. On inquiry the Usma Director informed the investigation that her mother is the aunt of the children's maternal great grandmother (the mother of the female caregiver, who frequently stayed at the caregivers' home with her husband, the family patriarch). This made the Usma Director the second cousin of the female caregiver and her sister (the maternal grandmother of the children placed under the kith and kin agreement).

Usma Director and protection case work

The Usma Director was a social worker and had delegated authority under the CFCSA, but her position was primarily a managerial one. She would take over the supervisory responsibilities of the Usma Supervisor when the supervisor was on holidays but she rarely, if ever, did protection casework and was not particularly comfortable in the role of protection worker. She certainly had never before been involved in a child death in

circumstances like these. At the beginning of September the Usma Supervisor was away. Also the contractor (an experienced social worker in private practice) whom Usma called on from time to time for consultation on protection issues was apparently unavailable.

Usma Director's call to helpline

On receiving the call from the female caregiver's sister-in-law, the Usma Director considered the issue of guardianship authority in relation to the child, and the question of MCFD's role because the caregiver's home was in Port Alberni. The kith and kin agreement was an out-of-care placement under which the parents remained the guardians of the child and her brother. The Usma Director reasoned that the child's mother might therefore have to be located if medical authorizations were needed. She sought confirmation of this by calling the MCFD after-hours client helpline. The Usma Director hoped that she might also be able to get advice about the allocation of authority and responsibility between Usma and MCFD. The MCFD helpline duty worker did not know details around kith and kin agreements, so his supervisor came on the line. The after-hours supervisor thought the Usma Director was right about the guardianship consequences of the kith and kin agreement, but could not help with the question of whether MCFD needed to be involved because kith and kin agreements were so new and he was not certain about the answer to that question. As the Usma Director said:

> ...they said kith and kin was too new, they didn't understand it themselves so they couldn't help me.
>
> ...
>
> I needed to understand, yes, because jurisdiction, of course, was an issue. I didn't know if there was something different.
>
> ...
>
> I wanted some answers from somebody else that might have more of an understanding.
>
> ...
>
> I told her the program that it was – the name of the program and that we had entered into an agreement, because I'm going to the hospital, I'm not sure if the child has died or not. And if there was papers to be signed, is it me that signs it, do we need to find the mother, does the Ministry need to be involved? She didn't know. She couldn't help me.

Usma Director meets with caregivers and other family members

The Usma Director met with the caregivers and other family members on September 5 to explore how the brother was doing and whether the caregivers could continue to care for him. In the absence of the Usma Supervisor, who was on holidays and not going to be back for another twelve days, the Usma Director decided that she was the one to take on the task of meeting with the family.

Earlier on September 5, the Usma Director had met with Usma staff to explain what had happened to the child. They were shocked and some reacted emotionally. Although the day was upsetting for everyone, the two Usma Protection Workers who had been involved with the kith and kin placement were prepared to carry out responsibilities in relation to the case and one specifically made herself available to the Usma Director to meet with the family. The Usma Director was nonetheless concerned that the two Usma Protection Workers were too shocked and stressed by the news to attend the meeting. Instead, she asked an Usma resource social worker (who did not have delegation for child protection work) to attend to record minutes.

The meeting was at the Usma office and the caregivers, the female caregiver's eldest brother and his wife (the sister-in-law who was also an USMA Protection Worker) attended.

The Usma Director started the meeting by explaining that information had to be gathered for the critical incident report to MCFD headquarters in Victoria. The male caregiver recounted the child's fall down the stairs. Plans for the child's brother and for a family meeting were discussed. The Usma Director explained that the brother could not be returned to his parents. The female caregiver's eldest brother expressed support for keeping the brother with the caregivers if they were willing. The male caregiver said he did not want to give up on the boy. The brother's aggression with other children was discussed, as was helping him with services such as play therapy. Overall the minutes of the meeting conveyed support for the child's brother continuing to stay with the caregivers and concern to provide the care necessary to deal with his violent behaviour.

The Usma Director came to the meeting accepting the explanation given for the death by the male caregiver. She did not approach the meeting with a critical eye to assessing risk to the brother's safety in the caregivers' home. She did not do an immediate safety assessment under the Aboriginal Operational and Practice Standards and Indicators (AOPSI) standards (see Appendix C.) The Usma Director viewed the purpose of the meeting to be seeing whether the brother was being supported or ostracized over pushing his sister down the stairs; exploring whether the caregivers (and their own children) were still able and willing to handle the aggressive little boy; and, if not, ensuring that he was not returned to his parents in whose care he had been assessed to be in need of protection. The fact of a tragic fall on the stairs was not questioned and no consideration was given to adult responsibility for what had happened. The Usma Director told the investigation:

> ...my focus was to try and get a sense of what was going on with [the brother] more than anything, not to try to determine what happened with [the child]. I felt that was in an area other people were trying to determine and that was – and I guess for me I took it at face value, that this is what I was told at the hospital and again during this meeting, that these are the events that happened. And it didn't – I mean, there was no flags of any kind, because it didn't appear anybody else – I didn't feel that anybody else was feeling any questions or concerns.

Usma's immediate response: Critical incident report

Both the Aboriginal Operational and Practice Standards and Indicators ("AOPSI") Level 15 Practice Standards require the Provincial Director to be notified of "reportable circumstances." These include the death or critical injury of a child in care or a child who has received services in the previous twelve months. The notification is done in a "critical incident report."

The child's death was clearly a reportable circumstance and on September 5 Usma, in consultation with Aboriginal Services at MCFD headquarters, assumed responsibility for preparing a critical incident report. One of the two Usma Protection Workers assigned to the case spoke with the police officer who had been at the scene the evening before and she recorded in the critical incident report that the police officer "had completed his investigation" and "concluded" that there had been a sibling fight during which the brother pushed his sister down the stairs. Usma's critical incident report was dated September 6 and sent to Aboriginal Services.

2.3 September 10–18, 2002: Communication of Contents of Interim Autopsy Report to the Child Welfare Authorities

Between September 10 and 18, there was a series of communications among the Coroner, the Police Officer, Aboriginal Services, other parts of MCFD headquarters, the district MCFD and Usma. Some of the evidence about those communications is difficult to reconcile. What is clear is that the information about the child's injuries was incompletely and unevenly communicated, and what the protection workers (Usma and district MCFD) who were charged with the responsibility for deciding on the risks of leaving the brother and other children in the home of the caregivers did know about the circumstances of her death was confusing or misleading for them.

Background: The obligation to report child protection concerns

Section 14 of the CFCSA imposes a legal duty to report if a child needs protection. Sections 14(1) and (2) read as follows:

> 14 (1) A person who has reason to believe that a child needs protection under section 13 [the child has been or is likely to be physically harmed or sexually abused or exploited etc.] must promptly report the matter to a director [under the CFCSA] or a person designated by a director.
>
> (2) Subsection (1) applies even if the information on which the belief is based
> (a) is privileged, except as a result of a solicitor-client relationship, or
> (b) is confidential and its disclosure is prohibited under another Act.

When a protection report is made, child welfare officials (a director under the CFCSA or their delegate) must assess the information in the report, and if warranted, investigate the report regardless of whether there is or may be a criminal investigation of the matter.

Information sharing between Coroners Service and MCFD

The Coroners Service and MCFD had developed a protocol for information sharing that included an immediate report (a "Kimble report) to MCFD headquarters with initial information about the death of a child and was set out in a memorandum of understanding between them. The law was not an impediment to sharing information for the purpose of protecting children.

"Kimble" report

The "Kimble" report is a one-page static report, with no system for updating, by which the Coroners Service alerts MCFD to initial information about the death of a child. In this instance it was sent by the Coroners Service to MCFD headquarters on September 6. It contained information that the Coroner had recorded on his investigative worksheet on September 4; namely, the account of the brother pushing his sister down five steps, information about the 911 call and emergency medical care, and the Coroner's note: "NO foul play suspected."

MCFD headquarters does not routinely send copies of "Kimble" reports to local offices, and in this case the "Kimble" report was not sent to the district MCFD or Usma.

Information-sharing MOU

The Coroners Service and MCFD had (both then and now) in place a two-page information-sharing memorandum of understanding dated May 1, 1999. For the death of a child in care or who had received child welfare services, it provided that:

> The local Coroner will supply to MCF preliminary information, i.e. cause of death, as appropriate and a copy of his/her final report on the death.

Neither the local Coroner in this case nor the Aboriginal Services Practice Analyst was aware of the memorandum of understanding. The manager responsible for case review in the Quality Assurance branch was the MCFD's liaison regarding the memorandum of understanding. She had been involved in its formulation and told the investigation:

> **A.** We kept it general so that it was really based on the principle that we would cooperatively share whatever information was required for them to obtain sufficient information about the Ministry's involvement that would assist with their investigation. That's really what it was. It was mostly information going to them from us. It also enabled them to provide us with information. So as an example, if they – when they had done the preliminary autopsy, they could share that with us, that document, and then they could share the final report with us.
>
> **Q.** Was that actually discussed at that time, the idea of sharing the preliminary or interim autopsy report?
>
> **A.** Yes, for this very issue. If we've got suspicious injuries, we need to know what they are and we need to make decisions based on that additional information about a death.

This manager also explained that her role as MCFD liaison with the Coroners Service was never intended to exclude communications between other MCFD officials and a local or regional coroner about a child death:

> It became apparent [in 1996] that, due to the increased number of Coroner investigations into suspicious deaths and the increased number of ministry reviews, the Coroner and the ministry needed a framework to share information that did not rely on a highly legalistic format of using subpoenas. It was evident to both agencies that we needed to establish a business arrangement that would facilitate this. The actual MOU was initiated by the Chief Coroner's Office. So the actual custodian of the MOU is that office.
>
> A preliminary discussion occurred sometime in 1996 that lead to the establishment of the MOU, and the subsequent updated one in 1999. Between 1996 and April 2003, the ministry contact for the MOU was me. Between 1996 and 1998, I conducted most of the initial death reviews. I had the most reason to be in contact regularly with the Coroner from central agency perspective as a practice analyst responsible for child death review – conducting reviews, tracking fatalities, ect. During those years, I acted originally as the Superintendent's [of Family and Child Services] delegate to establish the MOU and later on behalf of the Director. Consequently, there were two roles I occupied vis a vis the Coroner's Office: the official liaison one, and a case management one for the conduct of child fatality reviews.

When I became the Manager of the Case Review Team, my role with the Coroner continued as the ministry liaison and contact responsible for the MOU. However, the practice analysts who conducted reviews had contact with the local or regional coroner when required to obtain information about a child's death. In fact, the intention of the MOU was to facilitate and support contact between the two agencies.

In the spring and summer of 2002, four or five training events were held with all the new deputy directors, practice analysts and administrative staff from the regions to prepare them for undertaking their new roles in quality assurance. Information was shared, documents provided regarding the various aspects of managing reportable circumstances, specifically, child death reviews and the role the Coroner had in obtaining information.

I was always educating staff about the role of the Coroner. This included practice analysts in the Aboriginal Services Branch. There was never a presumption that I was the only person to contact. The consequence of my having the most contact, because of my previous relationship with the Coroner, was that I was the staff person that staff of the Chief Coroner knew the best.

Legal context for information sharing

The memorandum of understanding, had it been known to those involved, would obviously have been a useful point of reference and tool. It was not necessary, however, to the sharing of the interim autopsy report with the child welfare authorities. On the contrary, with or without an information-sharing memorandum of understanding, no law prevented information about the circumstances of the child's death from being communicated to MCFD or Usma as protection reports or for protection investigations concerning children in the caregiver's home – not the *Freedom of Information and Protection of Privacy Act*, the *Coroners Act*, the CFCSA or any other statute, or any common law privilege.

The fact of the matter was that the cause of the child's death was legitimately important information for the respective functions of all three types of agencies: the Coroner, the child welfare authorities (MCFD and Usma) and the police. The information about the child and her family that was already known to the child welfare authorities became, when she died, also legitimately important information for the respective functions of the Coroner and the police. MCFD and Usma made their relevant files available on request to the Coroner and the police.

As for concerns about the sharing of information prejudicing a criminal investigation, Section 16 of the CFCSA expressly provides that the obligation to make all reasonable efforts to report the results of an investigation to the parent does not apply if a criminal investigation into the matter is underway or contemplated.

Circumstances around Coroner's perception of sister-in-law's role

The Coroner's perception of the role of the female caregiver's sister-in-law was a factor in his communications with Usma.

The sister-in-law was married to the female caregiver's eldest brother and was employed by Usma as a fully delegated protection worker. She had a geographically based caseload, like the other Usma protection workers, that did not include Ahousaht or other areas covered by the Protection Workers assigned to this case. The investigation heard that it was sometimes awkward to work on this case because of the sister-in-law's physical proximity in the close working quarters at the Usma office in Port Alberni, but that there was never any question at all that she was not assigned to the case.

The records reviewed by the investigation suggest, however, that there was a sustained perception in the Coroners Service that the sister-in-law was in fact working as an Usma protection worker on this case involving her close relatives.

At the hospital, the Coroner had spoken to a group that included numerous family members (among them the caregiver's sister-in-law), emergency responders, police, the Pediatrician, and the Director of Usma.

In the "Kimble" report sent by the Coroners Service to MCFD on September 6, the regional coroner included the comment, "Social worker responsible is relative of foster mother."

The Coroner spoke with both the Usma Director and the sister-in-law at the hospital on September 4. He learned about the Usma Director's association with Usma but was not aware of any kinship relationship between her and the caregivers or the children in their home. He became aware that the sister-in-law was related to the caregiver and was an Usma case worker either at the hospital or in her call to him first thing on September 5. On that day there were also several telephone contacts between the Coroner and the regional coroner or her office. All of this points to the words "social worker responsible" in the Kimble as being a reference to the sister-in-law.

The Coroner's lists of contacts at the front of his file recorded the child's parents and the caregivers as "family," the sister-in-law was recorded as Usma "case worker" and the Usma Director was recorded by her title. The only indications of the sister-in-law being "family" were that she had the same last name as the female caregiver and the name of her husband (the female caregiver's eldest brother) was also listed. The Coroner's file notes for September 4 also identified the sister-in-law as "case worker," but his notes for September 5 had "family contact" after the sister-in-law's name and his notes for September 6 had "family rep" before her name.

The Coroner told the investigation that he described the sister-in-law as "case worker" in reference to her position at Usma, not to her association with this case as a protection worker, and that he always interacted with her as a family member, not as a protection worker.

In March 2004 the Coroner nonetheless prepared a summary of events that repeatedly referred to the sister-in-law as an Usma "case worker" or one of the "Usma reps," with no indication that she was "family" and not a protection worker assigned to the case.

Also, an April 30, 2004 email from the Coroners Service to MCFD headquarters stated:

"The situation (i.e. release of information) was further complicated by the fact that Usma case worker was the sister-in-law of the foster mother."

September 10: Coroner is unclear about Usma's role and contacts district MCFD

The Coroner was aware of Usma's presence at the hospital on the day the child died. However, it was a new experience for him to be dealing with an Aboriginal child welfare agency and he was not familiar with Usma and its role. On September 10, having received the autopsy report the day before, the Coroner telephoned to the district MCFD to find out about Usma, and what its role was as a child welfare agency and in relation to MCFD.

Background: The lines of authority and responsibility for the protection and welfare of the children in the home

There were two different lines of authority and responsibility for the protection and welfare of the brother and the children of the caregivers during the time period covered by the story of their continued placement in the caregivers' home.

From ICEO/Regional Director to district MCFD Protection Workers

The first line of authority and responsibility was in relation to the protection of all the children and was based on the fact that the caregivers' home in which they were living was in Port Alberni. That line of authority was entirely within MCFD, starting with the MCFD Regional Director under the CFCSA, who was also the Interim Chief Executive Officer (ICEO) for the Region, and ending with the MCFD District Supervisor and the front-line MCFD Protection Workers, who held delegated authority under the CFCSA.

In terms of operational responsibility the District Supervisor reported to the Community Services Manager for the area, who in turn reported to the ICEO/ Regional Director. In addition, there was a Regional Assistant Director who reported to the ICEO/Regional Director and fulfilled her responsibilities under the CFCSA on a day-to-day basis.

From Provincial Director to Usma Protection Workers

The second line of authority and responsibility was in relation to the protection and ongoing suitability of the placement of the brother and was based on the fact that the parents of the brother, for whom there was an ongoing protection file, resided on the reserve at Ahousaht, and the brother had been placed (along with his sister) in the caregivers' home under a kith and kin agreement. This line of authority started with the MCFD Provincial Director under the CFCSA and ended with the Usma Supervisor and front-line Usma Protection Workers, all of whom held delegated authority under the CFCSA. The 1985 agreement between the NTC and the provincial Superintendent of Family and Child Services provided that the social workers employed by the NTC would have delegated authority for child protection from the Superintendent. By 2002, the Superintendent had become the Provincial Director under the CFCSA, whose child welfare authority/responsibility at the time was essentially limited to children living on reserve.

The Usma Director had operational responsibility for Usma. The Usma Supervisor reported to the Usma Director and supervised the Usma social workers, who had generalized caseloads that were assigned on a geographical basis. The Usma Director, Supervisor and Usma Protection Workers were all fully delegated by the Provincial Director to do protection work under the CFCSA.

Authority to remove

If a child is found to be in need of protection as the result of an investigation of a complaint, Section 30 of the CFCSA gives the director authority to remove, if:

> (a) the child[ren's] health or safety is in immediate danger, or
>
> (b) no other less disruptive measure that is available is adequate to protect the child[ren].

Usma's responsibility for the brother arose from protection concerns relating to his parents, not the caregivers. Therefore, Usma was responsible for assessing the caregivers' home not just from the point of view of investigating a protection report about him, but also under the kith and kin guidelines, to be satisfied about the acceptability of the caregivers' home in the context of a risk reduction plan. While the guidelines did not provide for supervision of a kith and kin placement, Usma had to be satisfied that the placement of the brother in the caregivers' home continued to be in his best interests after the death of his sister.

September 10: Coroner communicates with Aboriginal Services

Soon after his call to the district MCFD, the Coroner received a telephone call from the Practice Analyst in Aboriginal Services (a branch of MCFD headquarters), who was responsible for providing Usma with support services. The Aboriginal Services Practice Analyst recorded the following handwritten file note of that conversation, which did contain medical terminology found in the interim autopsy report:

> complete
> pathologist began post mortem Fri
> continued yesterday
> - doing microscopic work
> - organ retention
>
> further investigation underway
> - no evidence of cause of death yet
> - bilateral non-displaced rib fractured
> - callouses on previous ribs
>
> - contusion/laceration of liver
> - contusion posterior right atrium
> - tearing intestinal hemoperitoneum
>
> placement home 3 kids
> - mom uptown – Safeway with 8 yr old
> - father heard argument on stairs – told them to stop
> - other 4 yr old was witness
> - will call family tomorrow
>
> [name of Port Alberni Police Officer]

The Aboriginal Services Practice Analyst's recollection was that the Coroner also indicated he preferred dealing with MCFD headquarters and spoke disturbingly about Usma:

> [The Coroner] mentioned his concerns about an Indian agency doing social work. He wasn't aware of how long they had been operating in the community or that area, and he indicated he had no faith in the ability of that organization. He did mention he had concerns because they had placed the child with the relative who worked at the agency, a woman who worked at the agency, the child had been placed with her, and he didn't think that was very good practice. And he didn't have confidence in the agency because of that reason. It was a very disturbing conversation. He also gave details of the post-mortem, let me know, but advised that I wasn't to disclose that to anyone. He would only talk to Victoria. And most certainly I should not talk to Usma Nuu-chah-nulth about the details of that concern. But it happened. It was very disturbing.

The Aboriginal Services Practice Analyst thought he sought legal advice on the question of withholding information about the child's injuries from Usma, but there was no evidence of this in the MCFD records that were available to the investigation or in the records and recall of MCFD's main legal adviser during this period.[4]

The Coroner's recollection was that he and the police were being cautious so as not to prejudice investigation of the death. They thought it better to share only that there were injuries not consistent with a fall down some steps. The Coroner told the investigation that he did not provide details of the child's injuries to the Aboriginal Services Practice Analyst, he did not recall saying that he preferred dealing with MCFD headquarters or had concerns about dealing with Usma, and he did not tell the practice analyst not to share information with Usma. About this last point the Coroner told the investigation:

> **Q.** ...Did you talk to [the Aboriginal Services Practice Analyst] about whether it was more appropriate for information to be shared directly to Victoria, than directly to Usma about –
>
> **A.** No.
>
> **Q.** ...Are you saying that didn't happen or you don't recall?
>
> **A.** Didn't happen.
>
> **Q.** If I was to say to you [the Aboriginal Services Practice Analyst] recalls on September 10th and again on September 12th being told by you that he was not to share information about [the child's] death – stuff that was in his briefing note on September 12th with Usma, would you say that could have happened?
>
> **A.** No.
>
> **Q.** Didn't happen, or what?
>
> **A.** I may have told him not to share information, meaning possibly the press or anybody else that might call, but I never specifically told him that he couldn't share whatever he had with Usma because I had a bit of an understanding at that point Usma was doing their thing but they [MCFD] were the overseeing agency and he [the practice analyst] was reviewing them.

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[4] No MCFD records were withheld from the investigation on the basis of solicitor-client privilege.

...

...I had spoken to the police and we were on a level playing field. This is what we were going to tell the family, what we were going to tell Usma. That was no concern. The family could know what Usma knows and vice versa. I think there was enough information in there to raise alarms to anybody.

Q. Was that the reason not to provide more; you had given enough?

A. No. I did not want to jeopardize, with the detail, the police investigation.

Q. [The Aboriginal Services Practice Analyst] told us on both the 10th and 12th you instructed him not to share the information with Usma, that you were relieved to be dealing with Victoria, and MCFD Victoria – to be providing information to them, it should not be shared beyond to Usma. Are you saying that just did not happen?

A. I am saying I wouldn't have said that because I knew they [MCFD] were the overseeing agency and he was supplying me with documents.

...

...I did not tell him he couldn't tell Usma what I told him.

Q. Just didn't happen?

A. Didn't happen.

September 10: Police Officer communicates with Aboriginal Services

On September 10 the Aboriginal Services Practice Analyst also recorded the following handwritten file note of a conversation he had with the Port Alberni Police Officer assigned to the case, which did not contain medical terminology found in the interim autopsy report:

- no definitive cause of death yet
- will talk to others at the scene
- hoping to get final autopsy by end of week
- it was the 4 yr old who witnessed/was present

- will talk to Usma tomorrow with Coroner
- also [male caregiver] is currently on probation for assault

The Police Officer's file note of speaking with the Aboriginal Services Practice Analyst on September 10 read as follows:

He advised that he had been notified by [the Coroner] of the investigation and that anything to do with First Nations related incidents such as this were dealt with directly through the Victoria office. He advised that Usma does not deal with the same set of standards for foster homes as does MCF. The assessment is generally more limited. Placement through Usma is an agreement between the parent and the designated caregiver. [The Police Officer] advised [the Aboriginal Services Practice Analyst] that [the MCFD Protection Worker] had been to the office and had been advised of the current situation. He advised that he would contact the Port Alberni office and touch base with him after talking to his own director.

Background: Separate but comparable protection standards

While the Police Officer's file note suggests that Usma does not deal with the same set of standards as MCFD, the relevant standards that applied in this case, although two separate documents, were materially the same, and understood to be so by the district MCFD and the Usma Protection Workers. The two standards documents in place in 2002/03 were the MCF Practice Standards for Child Protection (Appendix B) that applied to the district MCFD protection workers and the Aboriginal Operational and Practice Standards and Indicators ("AOPSI") Level 15 Practice Standards (Appendix C) that applied to Usma Protection Workers. Both included a mandate to carry out culturally appropriate practice.

In addition, Usma's practice, in terms of the placement decision for the brother, was guided by MCFD's July 2002 Draft Practice Guideline for Section 8 "Kith and Kin" Agreements (Appendix A).

September 10: Police Officer communicates with district MCFD

In the afternoon of September 10, the MCFD Protection Worker who ended up being assigned to the case met with the Police Officer at the Police Officer's request. The Police Officer's file note recorded that she told the protection worker that "as of now there was no definitive cause of death and that it may still well be that the death can be attributed to the fall but that due to the preliminary findings of the autopsy there was still an apparent abuse issue to deal with." The MCFD Protection Worker recalled the meeting as follows:

> – I can always remember this – that it was inconsistent, she said. It was either – the injuries were inconsistent with a fall down five stairs. Because I remember thinking after that, what does that mean, because it was a strange feeling hearing that.
> ...
> ...so I was kind of like, Okay, what does that mean? She said they're waiting for the Coroner's report and they don't know what it means. I remember saying, "Are you doing an investigation? Is there a concern?" "No, no, we're just waiting for the Coroner's report." I asked when. "Anywhere from one to two weeks." They're just waiting, I said, "If it's inconsistent." And I asked, "Is there concern?" "Well, no, we're not sure. We're still waiting for the coroner's report." I said, "Then technically it would be the Ministry who would investigate a home off reserve."

(September 10): Aboriginal Services communicates with district MCFD and Intake 12 is opened

Around this time the MCFD District Supervisor opened an intake on the death of the child, referred to as Intake 12. The call date was manually recorded as September 8 (this was a Sunday). Other indications are that it actually happened on the morning of September 10.

Background: Intakes

When a report is made that a child is in need of protection, a file is opened by the MCFD office or delegated Aboriginal agency responsible in the circumstances. The report, the file and the process of assessing the report are separately and collectively called an "Intake." In this case, both the district MCFD and Usma treated the report of the child's death as an intake. In Usma's case, it was opened on September 5 and entered as an "Intake – Non-Investigation."

When the MCFD Protection Worker got back to his own office after speaking with the Police Officer, he learned from the MCFD District Supervisor that earlier in the day Aboriginal Services had also been in contact about the child's death. The MCFD District Supervisor and protection worker discussed opening an intake and whether the indicated caller should be MCFD headquarters or the police. The MCFD District Supervisor made the decision to enter the initiating caller for Intake 12 as the "Deputy Director." This was the Deputy Director, Aboriginal Services, who was away on annual vacation until October 1. The caller was in fact an Aboriginal Services practice analyst who was covering her position, together on speakerphone with the Aboriginal Services Practice Analyst who was assigned to the case.

The Aboriginal Services Practice Analyst recorded the following note of the call with the MCFD District Supervisor on September 10:

> 9 broken ribs – 3 weeks old
> resource off-reserve – is this Nuuchahnulth or Port Alberni MCFD – whose jurisdiction
>
> autopsy – broken ribs
> - both sides of cavity
> - RCMP & pathologist called – 1 rib fracture - healing
> - not consistent with the story
> - u/k when fractures happened
> - doctor being called
> - call the Coroner
> - more specific info re dating the injuries

It was unusual for Aboriginal Services to be calling an MCFD field office. The call was even more unusual in that the caller said that information about the child's injuries or death being inconsistent with the story of her falling down some steps could not be shared with Usma. In some thirty years with MCFD the District Supervisor had never before been told to keep information secret from anyone like that. Omitting to record relevant information on an intake was a complete departure from practice. He accepted the instruction "with a frown" and complied with it by not entering the secret information when he opened Intake 12, because Usma could be expected to have access to information entered on the MIS SWS system. The MCFD Protection Worker's only knowledge of the call from Aboriginal Services was the expurgated initiating information that the MCFD District Supervisor entered on Intake 12.

The MCFD Protection Worker's meeting with police on September 10, like the secret information from Aboriginal Services, was not recorded on Intake 12.

September 11: Aboriginal Services prepares and distributes briefing note

After speaking with the police and the Coroner by telephone on September 10 and reviewing the MIS SWS print-out for the historical MCFD intakes on the caregivers, the Aboriginal Services Practice Analyst prepared a one-page briefing note dated September 11. The distribution list for the briefing note was the Deputy Director, Aboriginal Services (away on vacation at the time), the Executive Director, Aboriginal Services, the Provincial Director under the CFCSA, and the Deputy Minister.

The Provincial Director was sure he got the information in the September 11 briefing note about the preliminary autopsy results but could not say when. The Executive Director, Aboriginal Services had no particular recall of this briefing note but believed that he probably saw it or a version of it. The Deputy Minister was also on the distribution list, however, unlike the Provincial Director and the Executive Director, Aboriginal Services, there were no documents or information from any of the MCFD headquarters staff that pointed to the Deputy Minister having had any involvement in the operational handling of this case.

Two of the bullets under the heading "Key Points" in the September 11 briefing note said this:

- Further investigation indicates that no cause of death has been determined as of yet; preliminary autopsy results indicate injuries not consistent with explanation given by the caregiver…
- Further RCMP investigation is underway.

One of the bullets under the heading "Background" in the briefing note provided some details of the child's injuries, in medical terminology found in the interim autopsy report:

- Preliminary autopsy results indicate bilateral non-displaced rib fractures in various stages of healing, contusions/laceration to liver, contusion on posterior right atrium, tearing of intestinal hemoperitineum—microscopic analysis of organs is ongoing.

Neither the MCFD district office nor Usma had knowledge of the briefing note, and the investigation found no indications that it was ever circulated outside MCFD headquarters.

September 11: Police Officer, Coroner, Usma and family meet

On September 11 the Coroner spoke to the pathologist about an update on the cause of death and recorded that it was still under investigation. This was the first of numerous telephone calls that the Coroner made to the pathologist in pursuit of autopsy results.

On that same day, the Coroner also asked the female caregiver's sister-in-law to set up a meeting with the Usma Director. The sister-in-law was ill at home, but her husband, the female caregiver's eldest brother, was not able to attend the meeting on behalf of the family, so she went despite having strep throat. The meeting between the Coroner, the Police Officer, the sister-in-law and Usma Director happened in the afternoon at the Usma office.

This was the important first opportunity after the autopsy for the Coroner and police to provide Usma with information. Unfortunately the purpose of the meeting and the sister-

in-law's presence at it were not commonly understood and the Coroner and Police Officer were left with a remarkably different impression of what happened than the sister-in-law and the Usma Director.

Police Officer's perspective

The Police Officer's record of the meeting said: "They were advised by [the Coroner] that as yet there is no definite cause of death but that there were findings of other injuries that needed to be looked at. He did not elaborate on what those injuries were or when they may have occurred." The Coroner's file note said: "Advised of 'issues' with regard to other inquiries found during autopsy." The Police Officer and the Coroner believed the fact the autopsy had been halted to arrange police presence, which both the sister-in-law and the Usma Director knew, was an obvious indication of suspicious circumstances. They were both sure that the sister-in-law and the Usma Director were told the child's death was suspicious. As for the presence of the sister-in-law, the Coroner said he asked her to set up the meeting but had no expectation about whether she would attend it, whereas the police officer thought it made no difference whether the sister-in-law was there or not.

Coroner's perspective

Of this meeting, the Coroner said:

A. …I was concerned about it interfering with the police investigation…if we told them this child had injuries not consistent with the fall down the stairs, that would be enough to tell anybody that something is not right here, and they –

Q. And they?

A. They would have to make whatever decisions they had to in their field. It is not my field. I did my duty and reported there was injuries to that child not consistent with a fall down the stairs.

Q. And if they needed more information from you they should have asked for it through the right channels? That is what I hear you saying. Am I right? They are supposed to know their job. If they need more information, they come back through your channels?

A. Right. And if there is legislation that says that I cannot withhold that information then they should have presented it to me because I can't be familiar with every Act that is out there.

Q. So everyone is on the same wavelength?

A. Right. They should have shared that information with me and I would have talked to my bosses and said, look, this is what the Children and Families Act says. Can I – and I am sure they would have said yes.

Q. Something would have shaken out here?

A. Yes. Absolutely.

The Coroner also said that had he known at the time about MCFD's oversight relationship with Usma, he would have left it to MCFD to communicate with Usma and would not have made the effort to have a meeting with the Usma Director at all.

Usma and sister-in-law's perspectives

The sister-in-law and the Usma Director thought the purpose of the meeting was to inform them about the Coroner's process. They were both sure that they were not told the death was suspicious. The sister-in-law thought the meeting was for the family because she had been asked to set it up and she had no professional role in the case. She did not know why the Coroner would ask her, as a family member, to set up a meeting with Usma, or why she would be asked to set up a meeting that she was not expected to attend. The presence of the sister-in-law also caused the Usma Director to think the meeting was for the family.

Had the Usma Director or the sister-in-law perceived that they were receiving protection report information under Section 14 of the CFCSA, the Usma Director would have made notes and brought in another protection worker, and the sister-in-law, as a family member, would have left the meeting. The Usma Director made no notes at the meeting. The only record of it in the Usma case files was the following excerpt from an "update from staff meeting" on September 16:

> ...Autopsy has been performed but they are doing more testing to determine the cause of death. [The Usma Director] met with the Coroner and an Investigating Officer from the RCMP and they are still trying to determine the cause of death.

The Coroner and the Police Officer did not think it was prudent or necessary to disclose details of the child's injuries in the interim autopsy report. They believed Usma and the family had enough information to know the death was suspicious.

The Usma Director and the sister-in-law understood that the cause of death remained unknown and they did not connect this and the fact of police presence at the autopsy with suspicious circumstances. Their perspective was that the child, pushed by her brother, had fallen down some steps. They believed the Coroner's process would determine why the fall, which they did not doubt had happened, was fatal.

September 12: Aboriginal Services Practice Analyst talks to Police Officer and Coroner

Aboriginal Services Practice Analyst talks to Police Officer

On September 12 the Aboriginal Services Practice Analyst spoke again to the police. His file note read as follows:

> [name of Police Officer]
> - did not tell Usma details of injuries
> - have requested copies of files
> - have requested [USMA Protection Worker] – resource worker – to come to office for more information
> - still waiting on details of pathologist
> - advised MCFD to let Usma know details of previous investigations – concerns for
> - immediate safety of children still in the home

The Police Officer's file note read as follows:

> He was advised that [the brother] was still in the care home and had not been removed

as earlier thought. He stated that he had been in contact with the local MCFD director, [the MCFD District Supervisor], in regards to protection issues with the children still in the residence. He advised that there were other incidents on file with their agency in relation to [the male caregiver] that caused him concern and that he had instructed [the MCFD District Supervisor] to pull those files and review them. He was advised that until we knew for certain what the cause of death is we were still going to continue with background checks/information to all the parties involved with the deceased. He was advised that if MCF was going to remove the children from the home then they should be doing it based on what they have documented in their files based on past incidents and of course the most recent incident not the fact that we still have an open file. He was advised that the cause of death may be attributed to natural causes however given the preliminary findings of other injuries that would be something this office would still have to investigate. [The Aboriginal Services Practice Analyst] advised that would be in touch as to whether or not he would request a meeting with this office and Usma jointly to discuss the protection issues and possible removal of the children from the home.

Aboriginal Services Practice Analyst talks to Coroner

On September 12 the Aboriginal Services Practice Analyst also spoke again with the Coroner and his file note read as follows:

[name of Coroner]
- asked for asked for copy of the file
- mothers file 2 1/2 inches
- caregivers – not much on file
- can't tell family details
- police said not to tell details of injury
- lots of history on family

The Coroner's file note read as follows:

Call from [Aboriginal Services Practice Analyst]
MCFD requested update
Re: meeting with Usma
- discussed same
- [MCFD District Supervisor] 720-2650
- local MCFD office instructed to look up additional info
- to call him in a day or so

The Aboriginal Services Practice Analyst and the Coroner again had different recollections about if and what was discussed about sharing information with Usma. The Coroner recalled no discussion in this call about the sharing of information. In contrast, the Aboriginal Services Practice Analyst recalled the following:

...he [the Coroner] again expressed his lack of confidence in the ability of the agency [Usma] to keep information confidential.
I explained to him about the – that it was a difficult situation for us, the potential problems, that if we can't disclose the safety concerns to the agency, that we're in a difficult place there. But he still would not allow us to disclose the information to the agency, forbade that that happen....

When examined again, the Aboriginal Services Practice Analyst told the investigation:

Q. On the 12th it says "Can't tell family details, police said not to tell details of injury." What I'm trying to get at, these telephone notes on the 10th and the 12th with respect to [the Coroner] and you, there is nothing in those notes about specifically don't tell Usma or concern about sharing information with Usma because they're a native organization or anything like that. So I'm asking you, do you think you recorded that information somewhere else?

A. I don't think I recorded that in hard copy. I know we had discussion, but I don't think it was written down.

Q. Do you remember what your thinking was on that in terms of whether or why it should be written down or not?

A. I found it to be disturbing. But it's not something I would ordinarily write in worker notes, because we're working as a government social worker, and it's not something that I would necessarily write in the notes.

Q. Because it's upsetting or you don't think it's an appropriate thing to write down?

A. Not appropriate to write down, although as a social worker we would be told of – we would use that when – these nuances that there was language that – just a sensitivity that we didn't feel it would be appropriate for that kind of information to be recorded in a government file.

Q. Information that was obviously –

A. Yes, information that would be offensive to be recorded in a government file.

Q. When I talked to [the Coroner] a couple of weeks ago, he categorically denied not just that he – I asked him directly, because I felt I had to, I felt it needed to be done, whether or not he recalled or did say to you – and I referred to what you had said in your transcript to us about concern about giving this information to those Indians, Indians doing social work, that kind of thing.

A. Yes.

Q. He denied that. He certainly said he didn't recall it happening. But he also said…that he was quite certain that he never asked or directed you to selectively withhold information from Usma. So that's why I wanted to talk to you again, not to try to convince you otherwise, but to make sure that we have a real clear dialogue between us about how clearly or not you recall that.

A. I recall that really, really clearly, that he said not to disclose information about the nature of the injuries to any of the staff at the Usma agency. I explained to him that they are the Director, they have the same confidentiality criteria that a Ministry staff person would have, and that they have to keep things confidential and that it would be compromising the relationship that we have with the agency of sharing information with them. And he categorically said not to disclose information about the nature of the injuries to the agency staff, not to do that.

Q. Which brings me to my next question, and that is, how sure are you that…the injuries you wrote down in the upper right-hand corner on the chit or telephone slip that has [the Coroner's] name on top of it and it has the date September 10. I take it that everything on that slip is your handwriting, is that right?

A. Yes, it is.

Q. How sure are you that that information there on that slip came from [the Coroner] and it came from him on that occasion?

A. I'm as sure as I am about anything else, very clear. I recall that information, I recall that telephone conversation where he was telling me that, and I was writing it down on the phone as he was going over these things. He talked about the pathologist in Vancouver doing work and wanting to get some of this information back. He was quite chatty about the process, and he talked – this is the information that he gave me at the time, clearly.

Q. Is there any possibility, in your recollection or in your mind, that the injuries that are in the upper right-hand corner of page 51, that you got that from someone else?

A. No, I'm positive it came from him on that day.

Q. Any possibility it came from [the Port Alberni Police Officer]?

A. No.

September 17: Coroner and MCFD District Supervisor meet

On September 17 the Coroner and the MCFD District Supervisor met at the MCFD district office. The Coroner had already been in communication with Aboriginal Services, but this meeting was the important first opportunity for a direct exchange of information between the Coroner and the district MCFD.

MCFD District Supervisor's perspective

The MCFD District Supervisor's recollection was that the meeting started out similarly to his telephone call from Aboriginal Services on September 10, in that the Coroner told him that what was going to be discussed could not be shared with Usma. The Coroner said he wanted to make the MCFD District Supervisor aware that there were other issues about the child's death; she did not necessarily die from a fall down the stairs and there was another contributing factor. The MCFD District Supervisor asked about that contributing factor and the Coroner said he could not share it. The MCFD District Supervisor asked for a document he saw on the Coroner's knee. He was told it was preliminary Coroner information that could not be shared until it was firmed up. The MCFD District Supervisor made no record of what he was told; he thought the Coroner might have said more about the child injuries in the meeting but could not recall.

Coroner's perspective

In his file the Coroner recorded that at the meeting he did an "in depth review of file c/w sw notes on file (not public) and review of 11 intakes as faxed by [Aboriginal Services Practice Analyst]." His recollection was that he would also have disclosed to the MCFD District Supervisor that the child had injuries that were inconsistent with the fall down the stairs and that he did not say not to share information with Usma. About this last point the Coroner told the investigation:

Q. ...do you recall telling [the MCFD District Supervisor] he must not share with Usma as well, when you met with him on September 17th?

A. No. Because I know those two agencies are working together and sharing information about these files all together. It's up to Usma when they are doing this placement with [the child] at the time, it was Usma that had to call Ministry of Children and Families to see if there is any concerns from their perspective. Nothing to do with me. But it was a sharing of information. I knew that is what was going on. Why would I tell [the MCFD District Supervisor] or [the Aboriginal Services Practice Analyst], don't talk to each other?

Q. I don't know.

A. Not happen.

Q. Just didn't happen?

A. Didn't happen.

Q. If [the MCFD District Supervisor] says that that categorically happened, it just didn't?

A. If that's [the MCFD District Supervisor] saying it did, he testifies to his. I am testifying to mine and I am telling you the truth.

Q. And on your knee you didn't have the information about the details of [the child's] death when you met with him? You didn't read it? He didn't ask you for a copy of it and you didn't say no? It didn't happen?

A. I don't have a recollection to that.

...

I am saying I may have had some documents with me but I – I wouldn't have given [the MCFD District Supervisor] that information at that point.

Q. Can you then, or since – do you know of any reason why there would have been a justification to differentially share information about [the child's] death with MCFD versus Usma?

A. No.

Q. Should have been the same?

A. Yes.

Q. And you agree with it now?

A. What do you mean? Now as opposed to then?

Q. And then. That is what I want to know. And that was your conviction then?

A. Absolutely.

Asked about his understanding at this meeting of the role of the MCFD District Supervisor, the Coroner said:

Q. ...What did you think he was doing? Did he tell you what he was doing, or –

A. He was giving me information that he was directed to give me by [the Aboriginal Services Practice Analyst].

Q. Did you think his office was engaged in any official duties of their own?

A. No.

Q. None?

A. None.

Q. If [the MCFD District Supervisor] had handed you a letter on September 17th, like the one he sent to [the regional coroner] on March 27, '03, would that have changed the landscape completely – a letter saying he is doing an investigation?

A. Absolutely. I would have taken that letter, faxed it to [the regional coroner], got her authority and did what she would have done.

Confusion about duty to report and provide information

The letter referred to by the Coroner in the previous quote is a standard form letter indicating that the agency (district MCFD or delegated Aboriginal agency) is involved in completing a child protection investigation as mandated under Section 16 of the CFCSA. The letter requests copies of all statements and police documents involving the child because that information is required for an investigation. The last paragraph in the letter read as follows:

> A copy of his/her consent is not required, as the above factors have been assessed as reason to believe the child/ren may be at risk of harm and determined to be reportable under Sec. 14 of the Child, Family and Community Act [*sic*].

Interestingly, on September 5 Usma had sent just such a letter to the police.

The supervisors and protection workers at the MCFD district office and Usma told the investigation that it did not occur to them that it would be necessary to send a letter of this kind to the Coroners Service; however, they would have done so instantly had they learned or been told that it would make information about the circumstances or cause of the child's death more forthcoming from the Coroners Service. As the Usma Supervisor put it:

Q. ...Did anyone ever suggest to you that there would be any use or necessity to send a letter like this to the Coroner?

A. No. In all my conversations with the Coroner, there was never any request or suggestion or any information passed to me that I should – I could gain more information from a written request. I believed that he was providing me with the information that he knew, and I was having very regular contact with him by phone. And he didn't indicate a letter would be advantageous to our office to complete.

Q. If it had been made known to you that you could have gotten potentially or actually more information about [the child's] death or more complete information or more documented information, gotten that information earlier by sending a letter like this to the Coroner, would you have done so immediately?

A. Definitely I would have. We had never dealt with the Coroner before, so certainly if there was a process that they had in place, his office had in place, that would have elicited more information, we would have used it.

Q. ...had you dealt with the Coroners Service before?

A. I've never dealt with the Coroners Service.

Q. At that time had you ever dealt with a child death on one of the files that you either had as a social worker yourself or that you were supervising?

A. No. I never had a child death.

For his part the Coroner was unfamiliar with child protection investigations, this kind of letter, any process for sending such letters to the Coroners Service, or whether MCFD and Usma were doing investigations on this case. As he put it:

> **A.** …I was not aware [the MCFD District Supervisor] was doing an investigation.
>
> **Q.** Were you aware that [the Usma Supervisor] was?
>
> **A.** No. She was satisfied with whatever information I gave her at the time, was my interpretation.
>
> **Q.** Maybe she didn't know what to ask for. I don't know.
>
> **A.** She asked for a copy of the autopsy report. I indicated to her that would not be available until after the Coroner's investigation and the police investigation was complete, and I put her name on the list.

His understanding of a duty to report to child welfare officials was limited to the Coroners Service's "Kimble" report process:

> …I was not aware of that Section 14…
>
> I was aware of the duty to report. The duty to report came through the Kimble to MCFD. I thought there was an obligation on my part at that time to report it to Usma, because I had a vague understanding of how the system worked. So I made arrangements to go tell Usma there was injuries to this child inconsistent with a fall down the stairs and so forth.
>
> At no time – at no time did [the Aboriginal Services Practice Analyst, the MCFD District Supervisor, the Usma Supervisor, the Usma Director,] or anybody else ever say, you know, under section such and such – 14, you have to tell us, because if that had been pointed out to me, at that point I would have reviewed it and reconsidered and called my supervisor and said to my supervisor, look, there asking for this under section such and such of MCFD. What do you want me to do? At no point did anybody tell me that section was there and relevant, so I treated it as a routine request. That is why I treated [the MCFD District Supervisor] like I did. At the time I wasn't going to release it to him. I don't know how much clearer I can put that.

September 18: MCFD District Supervisor excludes "vital details" from MCFD Intake 12

On September 18 the MCFD District Supervisor emailed the Aboriginal Services Practice Analyst to ask him to review the information recorded up to then on Intake 12. He said district MCFD was investigating and added:

> I have not included some vital details in this MIS case as I do not wish to enter information I am not at liberty to write down. Also, as the NTC [Usma] may very well get access to this file in the future, I do not want anything untoward entered at this time. We will be able to enter the information in the future.

On the same day there was an email from the MCFD Community Services Manager to other managers that said:

> I spoke with [the MCFD District Supervisor] just now. He has met with [the Usma Supervisor] and his office will be doing the investigation into this child protection

> concern. He has spoken with the RCMP and the Coroner and they have asked him not to disclose to NTC the fact this child had previous injuries that were healing.

As it turned out, the early information from Aboriginal Services, the Coroner and the police was not entered on Intake 12.

On September 18 there was also a meeting at the MCFD district office with the Usma Supervisor, who was just back from her vacation. The MCFD Protection Worker remained unaware of any direction not to share information with Usma. The Usma Supervisor reviewed and took away with her a print-out of what had been entered onto MIS SWS so far for Intake 12. She did not know that the MCFD District Supervisor had excluded information from Intake 12:

> ...There was never a discussion about him having information and not being able to provide it or being told not to provide it to me.

The same scenario would repeat six weeks later when the Coroner read the injuries from the interim autopsy report to the Usma Supervisor who, because she understood that she was not to record or share the information, did not enter her notes of the call into the Usma case file system and gave the information to no one outside Usma, including the MCFD District Supervisor. The MCFD District Supervisor and the Usma Supervisor were both left, reluctantly, withholding information from each other that should have been swiftly and accurately communicated between their offices.

Reconciling the evidence

The Aboriginal Services Practice Analyst was the only person at MCFD headquarters who spoke with the Coroner about this case. His file note of his call with the Coroner on September 10 and the September 11 briefing note he prepared both contained medical terminology from the interim autopsy report.

The Coroner had the interim autopsy report on September 9. It was faxed to the Port Alberni police at their request on January 22, 2003. It is highly unlikely that the police would have requested the interim autopsy report on January 22, as they did, if they already had a copy from the Coroner. There was no record of it on the police file prior to January 22. The interim autopsy report was never in the possession of MCFD or Usma.

The medical terminology from the interim autopsy report that was in the Aboriginal Services file note of the practice analyst's September 10 call with the Coroner and the September 11 briefing note he prepared, was not in the Aboriginal Services Practice Analyst's file notes of his calls with the Port Alberni Police Officer or the MCFD District Supervisor. Nor was it in the Police Officer's records of her calls with the Coroner, the Vancouver police officer who attended the autopsy or the Aboriginal Services Practice Analyst.

Those present at the autopsy (medical personnel and the attending Vancouver police officers) might have been other possible sources of information about the child's injuries, but there were no indications that they communicated with MCFD at any time. The Port Alberni Police Officer saw the interim autopsy report in meetings with the Coroner in September; however, no MCFD or police records or recollections pointed to the police as the source of the details of the child's injuries from the interim autopsy report that were recorded in the Aboriginal Services Practice Analyst's September 10 telephone note and the September 11 briefing note he prepared for the MCFD executive. Despite the Coroner's recollection to the contrary, it is most likely that he was indeed the source of that information.

The Aboriginal Services Practice Analyst's file notes of his calls with the Coroner said nothing about a stipulation not to share information. However the investigation examined six other officials in Aboriginal Services and in the Quality Assurance branch at MCFD headquarters who had involvement, sometimes peripherally, with the case and with the Aboriginal Services Practice Analyst as he was dealing with it. None of them communicated directly with the Coroner or the Coroners Service, but at the time they all obtained and operated under the belief that the Coroner had told the Aboriginal Services Practice Analyst not to disclose details of the child's injuries to Usma. They were all concerned that it was improper to withhold protection information from a child welfare agency and they speculated amongst themselves as to the reason for the Coroner's reluctance to provide information to Usma.

The MCFD manager in the Quality Assurance branch who had the MCFD liaison role with the Coroners Service explained that her branch was in major transition in the fall of 2002, winding down work, preparing regional MCFD staff for new expanded roles and managing staff changes for those staying at headquarters. Adding to this, several key headquarters staff were on vacation during August and September and, prior to September 4, another Aboriginal child had died under suspicious circumstances. These types of sudden deaths had not happened before in the Aboriginal child population with this MCFD working group. People were reeling with sorrow, shock and disbelief. Headquarters was described by her as chaotic and reactive at the time and this was in part attributable to the deaths of the two Aboriginal children. The result was a crisis-like environment, in which it was more challenging for MCFD headquarters to manage staff and their inexperience with these unexpected tragedies. She said:

> **A.** ...I remember feeling frustrated that I couldn't just pick up the phone and call them myself and say, "What's the deal here? The agency [Usma] and the Ministry work in partnership, and we need cooperation, we need to collaborate here to do ongoing planning for the surviving kids." And I felt frustrated. But I didn't do anything because it wasn't my area.

Given the poor quality of communication that hung over this case, there is the possibility that the Aboriginal Services Practice Analyst was entirely mistaken in his understanding that the Coroner did not want details of the child's injuries to be shared with Usma, and that he passed this misconception on to others at MCFD headquarters. It is less conceivable, however, that the MCFD District Supervisor fell into exactly the same misunderstanding when he met with the Coroner on September 17. It is most likely on the whole that the Coroner, despite his contrary recollection, did indeed also convey to the Aboriginal Services Practice Analyst, and later to the MCFD District Supervisor, too, that he did not want details about the circumstances of the child's death to be shared with Usma.

It is possible that the reason for this was the Coroner's concern that, because the female caregiver and the sister-in-law were Usma employees, the confidentiality and security of information passed to Usma might not be maintained which could in turn compromise a future criminal investigation. If that reason was the reason, it was not understood by those involved at MCFD.

Experts comment on significance of interim autopsy information about child's injuries

The investigation asked four physicians to read the interim autopsy report: the Family Physician who saw the child's brother on September 9, the Pediatrician who saw the child in emergency on September 4 and assessed her brother on November 7, and a pediatrician and a general physician from the Health Assessment and Resources for Children (HARC) which is one of British Columbia's five Suspected Child Abuse and Neglect clinics. (HARC's work is described in greater detail in "Usma makes contact then has no further contact with HARC," page 46.) None had seen the interim autopsy report before.

All four physicians were also asked to read the final autopsy report. The HARC physicians had previously reviewed the final autopsy report when consulted by protection workers in March 2003. The pediatrician who attended the child in emergency on September 4 had seen it before, briefly, when he testified at the February 2006 inquest into the child's death.

There is no question. The gross findings in the September 9 interim autopsy report, which are almost identically described in the January 2003 final autopsy report, are severe, overwhelmingly significant from a child protection perspective and immediately plain to a physician.

Some of the physicians' responses were:

- I could have instantly said those findings [the final autopsy report] were not consistent with a simple fall down the stairs, if anyone had asked....I would say exactly the same thing [about the interim autopsy report], that the kind of trauma that they're describing is severe and the kind of injury you expect from a fall down steps, four or five stairs, is minimal bumping and bruising. In fact, a fall down four or five stairs is actually a series of smaller falls from tread to tread, and so you don't expect anything other than superficial injuries from a fall down stairs.
- [I]f I am trying to put myself in the brain of a social worker who is not medically educated, they would have obviously understood that this child received significant trauma because she died. What they missed was that that couldn't have happened from a simple fall down the stairs. So they were expecting to see a lot of trauma because the child died. Kids fall down the stairs all the time. But obviously something was different in this case. Look, she had all sorts of trauma and then she died. What they were missing was the fact that this kind of trauma doesn't result from a simple fall down the stairs.
- I can't tell you based on autopsy findings who did what, when, but I can certainly tell you that the presence of previous injuries along with the injuries that caused her death make one realize that this child has been injured on more than one occasion. And the dating of the rib fractures, it's not exact to the day or the hour, but there is a range. So it's for the other investigators in this case to look at all the possibilities as to who would have had access to this child within the time frame of the healing of the rib fractures.
- Because I haven't dealt with an awful lot of child deaths, I don't know exactly how long the process takes for fixation and sectioning and examination of the microscopic findings. But you have a preliminary autopsy report.... [T]here is enough information there. You can make a provisional diagnosis that would have been very helpful for

everyone involved very early on in this case, just within days of this child's death. And the microscopy is supplemental information.

- [The interim autopsy report] shows that there is a huge amount of trauma that could really not be explained by the history that I was given…That this child had been pushed down maybe four, maybe five steps – not flights of stairs, actual steps. There are also some things that really come out. …if a child had been in a motor vehicle accident and had all these different types of injuries, fine. If it had fallen from a height…usually takes a significant amount of height onto a hard surface, at least about six or seven feet to sustain a lot of internal brain injuries. …So when you have this much with all the abdominal trauma and it shows here…lateral rib fractures some with callous formation. …All that is in keeping with abuse. There is nothing there that really could be explained from a fall, from that small height.
- [T]his [the injuries in the interim autopsy report] is a classical battered baby.

What these physicians said about the manifest severity and significance of the child's injuries was more or less consistent with the Port Alberni Police Officer's record of the message conveyed to her by the pathologist in his telephone call on September 10. The child's injuries were severe; they were not consistent with a fall down five steps; they included, but were by no means limited to, healing rib injuries that had happened at some earlier time.

The HARC physicians were also asked about the September 11 briefing note. The description of the child's injuries in the briefing note is a basically accurate albeit less medically technical description of gross findings in the interim autopsy report. From a physician's point of view, the briefing note is as alarming and significant as the interim autopsy report. As the investigation was told: "if you had just seen this document [the briefing note], there is enough wording in here to make you very, very concerned about the cause of the child's death. And this alone would cause great concerns."

Usma makes contact then has no further contact with HARC

Background: HARC

Health Assessment and Resources for Children (HARC) is one of British Columbia's five Suspected Child Abuse and Neglect clinics (known as SCAN teams) that provide specialized diagnostic and treatment services to children who are suspected to have been physically or sexually maltreated or neglected. The largest of these teams is the Child Protection Service Unit at BC Children's Hospital in Vancouver, which can be accessed throughout the province. The four other teams provide regional services: HARC in Victoria; the Children's Health Clinic at Royal Inland Hospital in Kamloops; the Northern Child and Family SCAN Clinic in Prince George; and the Health Evaluation Assessment and Liaison Team (HEAL) in Surrey.

SCAN teams use an interdisciplinary approach and, with slight variations, consist of medical, nursing, child welfare and mental health professionals. Depending on its resources and location, a SCAN unit may annually receive anywhere between 200 and 700 referrals.

HARC began providing services in 1999. Described as a service partnership of the Vancouver Island Health Authority, Ministry of Health and MCFD, HARC includes a

pediatrician, general practitioner, child welfare worker and other health care professionals. HARC services are available to protection workers, police and health care professionals for the assessment of children in cases where maltreatment is suspected. It also offers consultations for physicians, mental health professionals and police; linkages with a network of physicians and other professionals specialized in the field of child maltreatment; education relating to child maltreatment; recommendations for treatment; forensic expert opinions and second opinions; and preparation and assistance to health professionals who are required to attend court cases relating to child maltreatment.

Usma and district MCFD's awareness of HARC

Although Victoria-based, HARC serves all of Vancouver Island. In 2002/03 MCFD and Usma protection workers were aware of HARC and that its services were available island-wide and to Aboriginal child welfare agencies. While HARC involvement in protection cases was not common, some of the protection workers involved in this case had used its services in other cases and one Usma worker sat on a HARC advisory committee. The investigation was told that HARC handles calls directly from protection workers, usually from the Victoria area, while requests for services from central and north island protection workers almost invariably come through MCFD Child Protection Consultants.

HARC gives immediate attention to a request from a protection worker, team leader or manager, a Child Protection Consultant, police officer, Coroner or physician for consultation about child autopsy results. When its services were requested in March 2003, the HARC team became quickly and decisively involved in this case.

(September 16): Usma contacts HARC

On September 16 the Usma resource social worker, who had taken minutes for the Usma Director's meeting with the family on September 5, wrote a memo to the Usma Director entitled "HARC Assessment," with a copy to the Usma Supervisor (who would not return from vacation until September 17). The memo recorded that the Usma resource social worker had been asked to contact HARC and another health care professional about getting an assessment of the child's brother. It reported that the HARC duty worker said HARC had "a physician on staff who would be able to assist in reviewing the Coroner's report which outlines what contributed to the child's death" and that the HARC duty worker would also consult their staff psychologist about an appropriate service plan for the brother.

Usma has no further contact with HARC until March

Usma had no Coroner's report to ask HARC to review and initiated no further contact with HARC. Not until March 2003 was there any further communication with HARC about the case. This was initiated by MCFD after it was able to acquire from police a copy of the January 2003 final autopsy report. The HARC team quickly met with MCFD and Usma Protection Workers to review the final autopsy report and triggered MCFD to remove the caregivers' children. (Usma had in the meantime arranged for the brother to be assessed and provided with play therapy through non-HARC professionals.)

District MCFD does not access MCFD Child Protection Consultants

Except in the lower island, HARC was usually accessed through the MCFD Child Protection Consultants. The Child Protection Consultants were part of the regional MCFD operation.

Background: MCFD child protection consultants

The MCFD child protection consultant program was created in 1995 in response to the Gove Inquiry and government's decision to implement a risk assessment child protection model. The program was initially delivered centrally. Then consultants were transferred to the regions in 1997, while still maintaining the provincial program out of MCFD headquarters in Victoria.

There are four geographically assigned MCFD child protection consultants on Vancouver Island. Their role is to provide clinical consultation and specialized resources to protection workers and team leaders dealing with serious, complex or potentially contentious child maltreatment cases. This includes screening, initiating and facilitating referrals to specialized medical consultation and assessment services for maltreated children through HARC in Victoria and BC Children's Hospital in Vancouver.

The child protection consultants are a resource, outside of management, for line staff when they want an objective and fresh clinical view of a case. They are to promote multi-disciplinary collaborative child protection practice and to provide training and mentoring to the field in introductory and advanced risk assessment, investigative interviewing and child protection practice. They are to work collaboratively with referring protection workers and team leaders to review and discuss case-specific information, assess risk to children, and develop plans for risk reduction or elimination.

A 2002 MCFD program overview said the following about the referral process for child protection consultants:

> Each region should establish a referral process that meets the needs of workers, team leaders, CPC [child protection consultant] and managers.
>
> In the past social workers required permission of their team leader before initiating a referral to the CPC. This was effective and as credibility and trust was established between the CPC and the team leaders, this guideline and the need for it dissolved in many regions. This is one strategy a new CPC may consider instituting for a period of time.

There was no question that an MCFD Child Protection Consultant would have given attention to assisting in planning for the remaining children in a home where there had been a sudden and unexpected child death. And the child protection consultant assigned to the Port Alberni area did become quickly and decisively involved in this case, when a request for services reached her in March 2003.

Interestingly, the two Child Protection Consultants we spoke to were the only individuals in the child welfare system who were witnesses in this investigation who had had experience responding to child deaths. Some of the MCFD practice analysts and managers involved in the case had experience with historical fatality case reviews, but not one of the MCFD or Usma social workers or managers recalled responding to a child death on an active family service file.

2.4 September 17–November 8, 2002: District MCFD Investigation and Usma Decision to Continue Placement

During the period between September 17 and November 8, the district MCFD and Usma worked in consultation about the district MCFD's investigation into whether the brother and other children were at risk in the caregivers' home and about the overlapping decision that Usma had to make about whether it was in the brother's best interests to remain in the home. Unfortunately, however, the MCFD District Supervisor throughout this period and the Usma Supervisor as of October 31, understood, unbeknownst to one another, that, on directions from the Coroner, details about the circumstances of the child's death or her injuries were not to be shared with each other or, for Usma, with anyone at all. The district MCFD investigation concluded on November 8 with a decision that the children were not in need of protection. Usma looked toward the expiry of the kith and kin agreement on November 15, whether the brother should remain in the caregivers' home, and if so, under what legal auspices he should remain there. That culminated in a decision by Usma to leave the brother in the caregivers' home but to remove him from his parents' custody, which was done by an interim order dated November 8 that gave the female caregiver interim custody of the brother.

Background: Relations between district MCFD and Usma

Relations between the protection workers at Usma and at district MCFD in Port Alberni were collegial, respectful and co-operative. The investigation learned that these offices have enjoyed a long and successful working relationship. The enduring mutual regard of these protection workers remains evident, and no particular tensions between district MCFD and Usma were detected around culturally appropriate protection practice in relation to the services that were delivered in this case. As one protection worker said in the context of the crisis-oriented families with which they sometimes deal: "It's not a Nuu-chah-nulth thing. It's we are dealing with very dysfunctional families."

To September 17: MCFD District Supervisor looks at information about historical intakes related to caregivers

By September 17 the MCFD District Supervisor had reviewed the family service file on the caregivers; done a summary of the historical intakes (1 to 11) at the beginning of Intake 12; sent the summary by email to the Aboriginal Services Practice Analyst; and assigned Intake 12 to the MCFD Protection Worker in the district MCFD.

The information recorded on the MIS SWS historical intakes did not include interview or case notes from protection workers or written reports from schools, alcohol and drug counselors, psychologists, police or doctors, all of which had to be accessed in the paper files. The detail in the summary of the historical intakes that was recorded on Intake 12 indicates that the MCFD District Supervisor had reviewed both the information entered on MIS SWS and the MCFD paper files on the caregivers.

For this investigation the MCFD paper files were examined for information about the caregivers that was not entered on MIS SWS. For a 1998 intake in particular (on which

need for protection was not substantiated) there was significantly more richly detailed information in the paper files than what was entered on MIS SWS. The paper files provided more information about discussions with immediate and extended family members, more information about the involvement of the police, and more information about the protection workers' assessment of and response to the intake and the family's circumstances.

The more detailed information in the MCFD paper files was significant because it revealed the dynamics of the caregivers' relationship in terms of violence and substance misuse in their home. It revealed that the spousal assault by the male caregiver in late 2001 was not an isolated incident. It depicted the female caregiver's tendency, in a manner symptomatic of a battered spouse, to disengage and decline services in relation to their family problems.

The information in the MCFD paper files also presented a more complete and serious picture of intertwined dysfunction in the immediate and the extended family. It showed that senior extended members of the female caregiver's extended family knew and were concerned about the couple's struggles with domestic violence and the male caregiver's substance misuse, and that those problems were not resolved. The closing letter that was sent to the caregivers on the 1998 intake found the protection report unsubstantiated but it also said that "[t]he concerns raised regarding domestic violence, co-dependency and verbal/emotional abuse in the home have yet to be dealt with" and urged the caregivers "to address these issues to ensure that you are able to provide a secure and nurturing environment for your children."

The same issues emerged again for Intake 12. As the MCFD Protection Worker assigned to the case told this investigation:

> ...that was another feature which jumped out at me [from the 1998 intake on the caregivers], was the domestic violence, the drinking, the lack of engagement in any serious manner with MCFD. And that trickled out in our Intake 12 because we had such a hard time engaging [the female caregiver] in any meaningful way. And I still feel this way. It was just – it seemed like there was this shell game, almost. "I don't want to meet with you on this day, that day." So there was that. There were patterns which definitely went back years: you had the domestic violence and the drinking and the avoiding MCFD. And that was almost all present in Intake 12.

Usma never saw the MCFD paper files on the caregivers until they were shown them during this investigation. However, on September 18 the Usma Supervisor did receive the summary of the historical intakes on the caregivers that the MCFD District Supervisor had entered on Intake 12.

September 17: Usma Supervisor returns from holidays; Usma Director does not brief or discuss kinship connection

On September 17 the Usma Supervisor had come back from her annual vacation and took over supervisory responsibility for the case from the Usma Director. The Usma Supervisor was not briefed by the Usma Director about the September 11 meeting between her, the Coroner, the Police Officer and the sister-in-law or about any of the kinship connections between the Usma Director and the family of the child and her brother, which are outlined in "Usma Director's kinship connections," on page 21.

Perspective of Usma Director

The Usma Director was aware of her kinship connections to the family. When asked about their ramifications for her involvement with practice decisions on the case, the Usma Director explained that the perception that she would know more about a case involving her relatives is misplaced. To Nuu-chah-nulth communities, she "is" Usma, with authority to remove children from their families, and for that very reason her own family members in those communities are as likely to withhold protection information about other family members as to report that information to her.

The Usma Director had been close to her deceased first cousin, the male caregiver's biological father. (The connection between the male caregiver and the Usma Director's cousin was not acknowledged during the cousin's life.) The Usma Director said that she regarded this as her most important kinship connection to the case.

She said she did not think the spousal relationship between her brother and the mother of the male caregiver was significant because the Usma Director was not at all close to the male caregiver or his mother; nor was her brother close to the male caregiver, who had not lived with the couple during their relationship.

She also said she did not attach much significance to the blood relationship between her own mother and the maternal great grandmother of the children in the kith and kin placement, because the Usma Director was not close to her first cousin, the maternal great grandmother. And she said she was sure that the Usma Supervisor and protection workers on the case were aware of her kinship connections to the maternal side of the children's and the female caregiver's family.

The Usma Director told the investigation that she was not in a "grandmother" relationship to the children placed under the kith and kin arrangement or otherwise too closely tied to the case by family connections:

> When I look back at that period of time, I don't see it as in any way affecting me, because I had no strong ties to [the child and her brother], I had no feeling that – other than the fact that they were children that plans needed to be made for. I didn't view it in terms of connectedness to any of their family that might be involved, because at that point I didn't have any connection with them. At that point, there was no – there was no involvement in terms of social involvement, family involvement. There was none of that. There was absolutely none. And that's all I would go by, is my involvement with that family at that time.

Perspective of Usma Supervisor and protection workers

The Usma Supervisor and the two Usma Protection Workers assigned to the case said they were not in fact aware, with one exception, of the Usma Director's kinship connections to the family. The exception was the spousal relationship between the Usma Director's brother and the mother of the male caregiver; one of the Usma Protection Workers was aware of this and, for much the same reasons as the Usma Director, did not consider it particularly concerning.

At the time of the investigation, the Usma Supervisor and the Usma Protection Workers assigned to the case expressed discomfort with the extent of the Usma Director's kinship connections to the family, and particularly that she had not proactively disclosed those ties when working with them on the case. As Usma staff they relied on each other to

self-identify their kinship connections with Usma clients and withdraw from working on those cases. They were disappointed that the Usma Director had involved herself in consultations and practice decisions on this case without disclosing her kinship connections to the family.

The Usma Director led the case work concerning the brother in the days immediately following his sister's death, particularly in her September 5 meeting with the family and her September 11 meeting with the Coroner, police and sister-in-law. Quite apart from whether the Usma Director felt personally sure that her kinship connections with the families involved were not diminishing her objectivity as a protection worker, it seems likely that had her Usma colleagues been briefed about those connections they would have questioned or relied less heavily on the Usma Director's practice judgments on the case.

District MCFD investigates Intake 12

September 20: Decision to investigate

On September 20, the MCFD District Supervisor, in consultation with MCFD regional and headquarters managers, made the final decision to "go in" on Intake 12 and investigate to determine whether the children in the caregivers' home were in need of protection. This was seen as an appropriate course of action because of the uncertain state of knowledge about the cause of the child's death and the information sharing "issue" with the Coroner.

Background: Deciding to do an investigation, and deciding whether a child is in need of protection

Under Section 16 of the CFCSA, on receiving a protection report, the director (through his or her delegated protection workers) must make an assessment of the information in the report to determine whether there are sufficient grounds to investigate the protection report. In MCFD's Risk Assessment Model, this decision is called Risk Decision #1. If the information received in the report suggests a risk of future abuse or neglect, the protection worker responsible for the file moves on to the investigation stage. In this case, the district MCFD went to the investigation stage.

The protection standards and the Risk Assessment Model enumerate the various risk decisions that need to be made in the course of handling a protection file. Different risk decisions require different degrees of information gathering and assessment to make the decision.

Risk Decision #4 is deciding whether the child is in need of protection. Section 13 of the CFCSA sets out the circumstances in which a child is in need of protection. The potentially relevant circumstances for this case are:

> (a) if the child has been, or is likely to be, physically harmed by the child's parent;
>
> (c) if the child has been, or is likely to be, physically harmed ... by another person and if the child's parent is unwilling or unable to protect the child; and
>
> (e) if the child is emotionally harmed by the parent's conduct.

September 20: Teleconference with Provincial and Regional Managers and MCFD District Supervisor

The decision to proceed with an investigation on Intake 12 coincided with a September 20 telephone conference call about the case between the Provincial Director under the CFCSA and other MCFD managers.[5] In the lead-up to that call, the Community Services Manager for the area emailed the Regional Director, the Assistant Regional Director and the Deputy Director Quality Assurance on September 18, as follows:

> I spoke with the [MCFD District Supervisor] just now. He has met with [the Usma Supervisor] and his office will be doing the investigation into this child protection concern. He has spoken with the RCMP and the Coroner and they have asked him not to disclose to NTC the fact this child had previous injuries that were healing.

The Deputy Director Quality Assurance replied as follows:

> [The Community Services Manager] - thanks for copying me on this. [The Provincial Director] asked if we can try to have a conference call on Friday to discuss this, get an update and develop a plan for response. The safety of the children currently in the home is the primary concern. In terms of the Director's responsibility this is a little confusing but [the Regional Director] is the director for the investigation into the current child protection concerns about the home and [the Provincial Director] is the director for the aboriginal agency.
>
> Communications has had an inquiry focusing on the media on the policy on Kith & Kin and on who would conduct a review if none were done. Once the police investigation is made public they will probably ask more specific questions about the case.
>
> We will try to organize the call tomorrow.[6]

District MCFD and Usma worked together in consultation but without full information sharing

The district MCFD and Usma worked in consultation, but the directions to the MCFD District Supervisor to withhold information about the circumstances of the child's death made a true joint investigation impossible. Having MCFD do its own investigation could still serve Usma (and the brother whose placement with the caregivers Usma had facilitated) without information MCFD got from the Coroner being given to Usma. The information-sharing conundrum at MCFD was of course being dealt with behind the scenes and was unknown to Usma or the MCFD Protection Worker assigned to the case.

Applying the "likelihood" test

The emphasis in the running entries that followed on Intake 12 was on confirming that there was no "likelihood" that the children who remained in the caregivers' home were in need of protection:

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5 The Provincial Director under the CFCSA himself had no recollection of this conference call. Other participants in this call included the Executive Director, Aboriginal Services, the Aboriginal Services Practice Analyst, the Deputy Director Quality Assurance, the Assistant Regional Director and the Community Services Manager and the MCFD District Supervisor for Port Alberni. There may also have been other MCFD headquarters staff on the call.

6 The conference call did not happen until Friday, September 20.

2002 Sept 17 Call to NTC/[Usma Supervisor] to meet Sept18/02. Agreed that MCFD would investigate the safety of the remaining children at [the female caregiver's] home based upon the situation. As there is no confirmation of the reason for the death of the child it may be appropriate to remove any doubt of a "likelihood" that the other children are at risk by interviewing them.

[the Usma Supervisor] will meet with [the female caregiver] Thursday Sept 19th/02 and inform her of the process. [The Usma Supervisor] will co-ordinate with [MCFD Protection Worker]. [The Usma Supervisor] will confirm that the 2 sec 8 chn... were "pink medicalled"[7] at the time of the placement at [the female caregiver's]. All children will be interviewed during this process and she will provide a name of an interpreter for the deaf child....[8] MCFD will also be provided with the case notes of the information given to the NTC SW's as to the circumstances of the "fall" down the stairs. Apparently all the children were playing on the stairs when [the child] was pushed. Father was on the couch and ran to the stairs upon hearing the commotion.

2002 Sept 18: CSM[9] consult. RCMP advised to assist in any co-ordinated approach.

2002 Sept 19: p/c with [Police Officer]. Discussed co-ordinating our approach. [Police Officer] indicated that they still do not have a cause of death so I should begin my inv. [Police Officer] said that they (RCMP) will not know for another week or two on the causes of death and so they do not want to be part of MCFD inv. as it could be perceived as tainting their inv.

- D/S consult. MCFD to investigate the safety of the remaining children at [the female caregiver's] home based on the situation. As there is no confirmation of the reason for death of the child it may be appropriate to remove a doubt of a "likelihood" that the other children are at risk by interviewing them. To contact [Usma Supervisor] at NTC for update on her meeting with [the female caregiver].

- p/c with [Usma Supervisor]. She is to be meeting with [the female caregiver] later this afternoon. Should the meeting finish before 4:30 pm she will call to update me.

- p/c with [USMA Protection Worker]. Discussed interviewing [the female caregiver's] children and the need for an interpreter...and would act in that role during an interview. [Caregiver's child] goes to...school. I asked about interviewing [the brother]. [USMA Protection Worker] indicated his verbal skills...very poor making an interview not possible.

- p/c from [Usma Supervisor] (4:15 pm). She just returned from speaking with [the female caregiver]. [The Usma Supervisor] informed [the female caregiver] that MCFD would need to follow up with the family and interview all the children to remove any doubt of a "likelihood" that the other children are at risk by interviewing them. [The brother] will be having a full medical as well as a skeletal, [USMA Protection Worker] is to be setting this up. [The female caregiver] fine with MCFD interviewing all the children. [The female caregiver] will be expecting a call from MCFD tomorrow.

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7 **"Pink medicalled" referred to being medically examined before being placed under the kith and kin agreement.**

8 **The caregivers' eight-year-old daughter was hearing impaired.**

9 **"CSM" referred to the MCFD Community Services Manager for the area.**

Background: The "likelihood" test

The Section 13 test for child protection intervention is based, in part, on whether a child is "likely to be" maltreated in various ways. On July 31, 2002 the Director under the CFCSA circulated a memorandum about child protection practice standards procedure that was aimed at providing protection workers with a practical approach of interpreting "likelihood" in Section 13 (Appendix D). (The MCFD District Supervisor was aware of this memorandum.) It explains that Standards 10, 12 and 19 of the MCF Practice Standards for Child Protection (Appendix B) and the corresponding risk decisions in the MCFD Risk Assessment Model (Risk Decisions 1, 2 and 4):

> ...should be interpreted by using a "balance of probabilities" test – the same test used by family court judges to determine a finding of a child in need of protection. Likelihood should be interpreted to mean that based upon professional judgment, it is more probable than not that an event/situation will occur. Likelihood should not be interpreted to mean a slight chance or possibility that an event/situation will occur.

For Risk Decision 1, the decision as to whether to investigate a protection report, the memorandum discussed the "likelihood" threshold as follows:

- In accordance with Practice Standard 10, the child protection worker must have reasonable grounds supporting the probability that harm will occur based upon the information included in the child protection report, prior contact checks and other assessment sources carried out under Section 16 in order to conduct an investigation
- If the child protection worker believes that a child is less than likely to be harmed after assessing the information, the child protection worker under Section 16 of the CFCSA may:
  - offer support services to the child and family
  - refer the child and family to a community agency
  - take no further action

For Risk Decision 2, determining the investigation response time, the memorandum discussed the "likelihood" threshold as follows:

> ...The likelihood situations will remain a Priority 4 [within 5 days] response for investigation unless there is information in the report that leads the child protection [worker] to believe harm is imminent.

For Risk Decision 4, whether the child needs protection, the memorandum discussed the "likelihood" threshold as follows:

- For Practice Standard 19 and Risk Decision 4 - If the child protection worker believes based upon information from an investigation, that it is more likely than not that a child needs protection the child protection worker must complete a comprehensive risk assessment and ensure the safety of the child by developing a risk reduction service plan based upon the least disruptive measures.
- If the child protection worker believes that it is less than likely that a child needs protection, the child protection worker may
  - Offer and/or provide voluntary family services
  - Take no further action

The memorandum also offered further advice about interpreting the "likelihood" of harm and the criteria for assessment and investigating reports:

> - For practical purposes, "likelihood" should be interpreted by child protection workers to mean that there is reason to believe based upon known information that a child is more likely than not to be harmed.
> - Although the Risk Assessment Model response Priority 4 includes many categories that involve the likelihood of harm, each situation must be assessed individually in order to determine the appropriate priority and level of response.
> - Likelihood does not refer to the existence of risk but to the probability of risk that a child is likely to be harmed.
>
> ...
>
> The decision about whether to continue to assess the situation or to investigate should be based upon the factors associated with imminent safety and wellbeing of the child. Factors include:
> - the age of the child
> - vulnerability of the child
> - the exposure of the child to the potential source of harm
> - the severity/degree of the potential harm to the child
> - the immediateness of the potential harm to the child
> - previous child protection concerns relating to the child or to a sibling
> - other factors such as family history, drug or alcohol issues, mental health issues, lack of support systems, environmental issues

Of particular interest to this case, the memorandum gave three examples of "likelihood reports" that required investigation, one of which was "a child whose sibling has been abused by a parent or caregiver and the parent/caregiver is caring for the child identified in the report."

The "likelihood" test was also relevant to the assessment Usma had to make about the suitability of the caregivers' home. The test of acceptability of a placement in the guidelines refers to the circumstances in Section 13 of the CFCSA (when protection is needed). The test to be applied in an investigation of a protection report and in assessing the acceptability of a home is therefore similar.

The kith and kin guidelines read:

> If you are uncertain about whether to accept the alternative care provider as a placement for the child based upon the information arising from the pre-agreement checks:
> - discuss your concerns with the care providers in order to obtain their views and/or explanation
> - discuss your concerns with the child's family with the permission of the care providers in order to determine their views
> - discuss the pertinent information in consultation with your supervisor

The acceptance test is based upon whether any of the circumstances outlined in Section 13 of the CFCSA [including that a child has been or is likely to be physically harmed] are present. The care provider should not be accepted if any of these circumstances apply.

District MCFD and Usma focus on and interpret healing rib fractures

September 20: Usma hears of healing rib fractures

On September 20 the Usma Supervisor telephoned one of the Usma Protection Workers about information she had just received from the MCFD District Supervisor in a telephone call that day concerning the child's injuries. The call was recorded in the Usma case file as follows:

> Received information from MCFD that the Coroner has found evidence of old rib fractures on [the child's] body (rib fractures that are in the pre-calcification stage – healing). Need full body skeletal X-ray – X-rays of all body parts and complete medical completed on [the brother]....

One of the notes of a participant to the September 20 telephone conference call with the Provincial Director under the CFCSA, other provincial and regional MCFD managers and the MCFD District Supervisor, also had this entry: "Preliminary information from Coroner suggests injuries occurred prior to placement."

On September 24 the Coroner recorded in his file that he got a call from the Usma Supervisor in which she said she had heard from the MCFD District Supervisor about healing broken ribs. The Coroner noted that he told her:

> - advised nothing official or in writing & until we have something in writing & concrete police will not proceed
> - advised that there are possibly other issues

The shroud of uncertainty and secrecy around what the MCFD District Supervisor had learned about the child's injuries, and because whatever he did learn was not recorded on Intake 12, makes it difficult to determine whether the MCFD District Supervisor learned about the healing rib fractures from the Aboriginal Services Practice Analyst assigned to the case, an MCFD manager, the Coroner, or a combination of these sources. What is clear is that the healing rib fractures were the one piece of information about the child's injuries that MCFD did definitely share with Usma.

Linkage by Usma and district MCFD of child's death to maltreatment by mother

The news of the healing rib fractures and its disclosure to Usma was another important juncture for the protection decisions made on this case. It marked the start of the district MCFD and Usma Protection Workers making a linkage between the child's death from a fall down a few steps and the spectre that she had been physically maltreated while in her mother's care. This linkage led the protection workers to perceive that the mother, through her access to the brother (or other children in the caregivers' home), was the most likely child protection risk in the case, not either of the caregivers.

MCFD's July 2002 Draft Practice Guideline for Kith and Kin Agreements had not required Usma to get pre-placement medical examinations of the children (known as a "pink medical" on account of the colour of the paper form used) and none had been done. As a consequence, after the child's death, there were no pre-placement medical records

of injuries she and her brother may have had before they went to the caregivers' home.

This became significant when the protection workers learned of the child's healing rib fractures. Inappropriate physical discipline was one of the protection concerns about the parents' care of their children, and the brother had been reported to be physically aggressive. It made sense to the Usma (and MCFD) protection workers to attribute the child's healing rib fractures to pre-placement maltreatment. This led them to their reasoning that the earlier injuries might have contributed to her death when she had the tragic altercation with her brother on the stairs.

The Usma Supervisor described the implications of the news of the healing rib fractures, in relation to the child protection options for the case and the expectations for an autopsy report soon:

Q. Did you regard this information from [the MCFD District Supervisor] as important?

A. Yes, very important. It was very concerning. You know, we – I was not thinking of it in terms of harm in [the caregiver's] home by [the caregivers]. I was thinking of it in relation to the mother, particularly the mom, possibly the father, because previous investigations had indicated physical abuse, pushing, being rough with the kids and some inattentiveness on her part in terms of supervision. We didn't know what the timeline – we needed to know what the timeline was so that we could determine if it was in relation to her care, while they were in her care.

...

Q. ...if [the mother] had access to the kids, so even if [the child] got her fractures while she was in [the caregivers'] home before September 4 but they were inflicted by [the mother], is that reason to hold all the adults who were responsible for that child away from – to protect the children from all those adults, whether they're the ones that inflicted the injuries or not?

A. Yes, I guess – I mean, that would be a – that could be a way to address it. Given that we didn't know who, we didn't have a timeline and – I couldn't say what the healing stage was: I didn't know if that was six months, two weeks. We weren't going to speculate on that...But that was just our sort of natural assumption, that we thought it could be [the mother].

These children were cared for by many relatives, had access – were accessed by many, many different relatives. So it would result in us removing them completely out of any family environment and supervising or restricting access to everybody.

Q. ...At that point in time, September 20, did you have any idea, from information or just from any hope in your own mind, about how long it would take to get the autopsy report?

A. I though it would be – you would have it within a few weeks of it being started. And I don't know if that was ever – if I was given a time frame, but the feedback when I asked questions was that it was being worked on, it was coming, it was coming.

As time went on, the feedback that I got from the Coroner was that this was not usual, this was an unusual delay, and that the Coroner's office had concerns about the length of time this was taking.

So I thought it was going to be just a matter of weeks. And particularly on the 20th. We were receiving some information. I thought, Okay, if they are – things are moving

along. We're almost at a point where we're going to have a conclusion to the autopsy results.

Q. Then you will know better.

A. That's right.

Disproportionate attention paid to healing rib fractures

The district MCFD and Usma Protection Workers kept expecting the autopsy report any time and, in retrospect, they gave disproportionate attention, in the meantime, to the healing rib factures. There were a number of contributing factors to this: the healing rib fractures were the only details of the child's injuries that Usma had to work with until October 31; the September 11 briefing note at MCFD headquarters, recording the details of the child's injuries, did not go to Usma or to the MCFD district office; if other details of the child's injuries were "unofficially" conveyed to the MCFD district office, they were not recorded; and in any case, the protection workers did not have the medical expertise to understand about healing bones or the significance of the gross injuries described in the interim autopsy report.

The premise that the child's healing rib fractures were pre-placement injuries also fit within the protection workers' framework that the caregivers' home was an appropriate one that was supported by the extended family. The Usma Director's face-value acceptance of the male caregiver's account of the fall down the stairs was a fit for that framework, too. The assumption that the healing rib fractures were pre-placement injuries also supported the district MCFD's disinclination to remove children, especially Aboriginal children, from their families and its respect for the judgment of the extended family about the parental suitability of the caregivers. The persistence of these orientations was reflected in the MCFD and Usma Protection Workers' consistently treating the cause of death as an "unknown," rather than treating suspicion about it as "known," albeit incomplete, information that was relevant and necessary to rely on in its own right for child protection purposes.

September 20–October 2: Family Physician sees brother, calls Coroner and refers to specialists

On September 20, the same day Usma learned from the MCFD District Supervisor that the child had had healing rib fractures, an USMA Protection Worker took the brother to see a Family Physician in Port Alberni. The Usma Supervisor explained Usma's approach to consulting physicians and therapists about the brother after his sister's death:

> We gave the doctors what information that we had, which was that she had fallen down the stairs, possibly pushed by [her brother], and that there were autopsy results still pending. We gave the doctors what we had and what we believed, that that was the current status of the information. We didn't withhold any information from the doctors. We wanted them to evaluate medically with as complete information as we were able to give them, which included psychologists. It didn't matter who we were talking to about [the brother]. We gave them the information that we had available to us.

The Family Physician examined the brother and completed the medical form. His observations recorded on the clinical file included the following:

[the USMA Protection Worker] – [the child and her brother] sibling was staying with [the female caregiver]
- neglect issues and subsequent abuse
- [the child] pushed down stairs by [the brother] but fall probably not cause of death.
- [the child] had old untreated fractures.
- therefore do skeletal survey on [the brother]
- in [the female caregiver's] care since the 12th of August and she is the great aunt of [the brother's] mother
- age of injuries still to be determined
- [the brother's] developmental delay needs to be assessed by [the Port Alberni Pediatrician]

The Family Physician noted on the medical form that the brother was "fearful and did not interact with examiner." He referred the brother to a radiologist for full skeletal x-rays and to another specialist for an ear problem.

On September 25 the Family Physician telephoned the Coroner for background information about the child's death. The Coroner remembered the call and his file record indicated the Family Physician was "advised of possible issues – nothing concrete or in writing – awaiting pathologist's report." Although not recorded in the Coroner's file, he thought he also told the Family Physician that the child's injuries were inconsistent with a fall down the stairs and that was why the social workers were getting a medical examination of the brother.

Despite follow-ups by the Family Physician and Usma, the skeletal survey took longer than necessary to get done because of the unreliability of the female caregiver and the child's mother in making and getting him to appointments with the radiologist. It finally arrived on October 2 and uncovered only a healed fracture of a bone in the brother's hand. After receiving it, the Family Physician immediately referred the brother to the Pediatrician who had attended his sister in emergency on September 4 for further assessment. The one-page letter described the female caregiver as the child's "Great Aunt" and identified her by her correct last name but used an incorrect, though similar, first name and provided the following information:

> [The brother] and his sister…were apprehended and placed in the care of his Great Aunt [female caregiver with a similar, but incorrect, first name] as there have been some concerns about the parents neglecting the children. [The sister] recently died and at autopsy they found she had some fractures that I believe were ossified so there is now a question of abuse as well.
>
> When I examined [the brother] he seemed fearful and did not play or interact with me. At age four he was unable to dress himself suggesting some developmental delay. Whether it is this neglect or his CSOM [a chronically draining ear condition] and impaired hearing he would appear to have some speech delay. I am sending a copy of this letter to [the ear specialist] so that he can manage his hearing problems.
>
> Since we talked about this case it has taken a surprisingly long time to get him in for a skeletal survey which suggests an old metacarpal fracture.

Usma Supervisor learns more

September 19: Usma meets with caregivers to discuss MCFD historical intakes and criminal record of male caregiver

On September 19, having met the day before with the MCFD Supervisor and heard from him about the historical intakes related to the caregivers, the Usma Supervisor and one of the Usma Protection Workers met with the caregivers to discuss the MCFD historical intakes concerning the couple and the male caregiver's criminal past. At that time Usma still did not have the male caregiver's criminal record check, but the male caregiver nonetheless disclosed the following:

> ...[The male caregiver] is on probation for assault (Feb., 2001). His probation officer is... He is doing the Family Violence Program with [the probation officer] weekly (27 weeks). Probation shortened due to taking this program. Program to be completed at the end of February...[his record as a young offender described]...He had a shoplifting charge. Two assault charges in 1999 and 2001 as an adult. One domestic assault. Charged with arson 9 years ago. He had 2 years incarceration for robbery with violence when he was 18 years old. The Program has been helpful. They have open communication as a couple. He is attending counselling. Cultural practices are assisting him. [The caregivers] have been together for 9 years.

September 24: Usma Supervisor reviews historical intakes but not paper files

The MCFD District Supervisor and the Usma Supervisor met on September 24. This time the Usma Supervisor reviewed MCFD's historical intakes on the caregivers but she did not see the supplementary information in the MCFD paper file on the caregivers, particularly on the 1998 intake. She recalled a lengthy discussion about the 1998 intake, which she regarded as a significant investigation and the one that was most concerning in terms of understanding the child's death on September 4. The Usma Supervisor again had no idea that any information was being withheld from Usma about the circumstances of the child's death.

September 24: Usma Supervisor's level of concern rises

Later on September 24 the Usma Supervisor attended a meeting at the Usma office with the Executive Director, Aboriginal Services and the Aboriginal Services Practice Analyst assigned to the case, who had come from Victoria to meet with Usma staff. The meeting was mostly about what might be expected with the director's case review relating to the child's death. The fact that the cause of death was still pending the results of the autopsy was referred to in the meeting, but the details of the child's injuries were not.

The Usma Supervisor described her level of suspicion and state of mind about the case after the two meetings on that day as follows:

> Officially I was going based on what I was told. Unofficially, I mean, I didn't know what had happened to that child, and I certainly – you have all kinds of thoughts in your head, but I wasn't prepared to go just on my own layman's version of things. I sought information from the officials: the RCMP, the Coroner, the Ministry. And at that point they weren't telling us anything. So, yes, maybe it was [obvious] to them, but certainly to us, who had never had this happen, we wanted information from the people who knew how to deal

with these matters, Aboriginal Division as well, headquarters, whatever you want to call it. No one was telling us anything.

Now I look at it and go, our eyes, were they not wide open? I believe we were wide open. We wanted help. They wanted someone to tell us something so that we could respond properly and ensure the safety of the child that we were responsible for.

September 27: Second family reference

On September 27 Usma received the second family reference on the caregivers (dated September 4). It was from the female caregiver's second brother and was very positive. His responses to four of the seven questions on the reference form were as follows:

3. What kind of person is the Applicant(s)? (Include here personality traits, interests, concerns, strengths and weaknesses)

[Female caregiver] is very grounded & generous. [Male caregiver] is responsible and kind and disciplined. They are very involved in Culture and encourage their kids to take part.

4. What is the Reference's impressions of the applicant's marriage or close relationships?

I have witnessed very strong commitment of both parents wanting the best for all their kids.

6. What are the Reference's impressions of how each Applicant relates to his/her own children and other people's children?

They both are very good. Kind & generous to other children and deeply caring. They provide structure to their lives.

7. Does the Reference see any problem in placing a Child in Care in this home?

I see no problem at all. They have a safe & comfortable home.

October 2–3: Usma speaks with male caregiver's probation officer

On October 2 an USMA Protection Worker spoke with the male caregiver's probation officer. His most recent convictions were for an unprovoked assault on an adult male in June 2000 and his substance misuse–related assault on the female caregiver in December 2001. He remained on probation for the spousal assault until February 2003. The USMA Protection Worker was told that notes on the probation file indicated the male caregiver was very co-operative but had recently missed some counseling sessions because of the suicide of his sister in August and the death of the child in his home on September 4. The probation officer described the male caregiver as saying that he was "hanging onto his sobriety for dear life" during this time. Most of the male caregiver's offences were drug- or alcohol-related and the probation officer was not sure how he would do if he relapsed. The Usma file note indicated that there were "No concerns around violence to children."

On October 3 the USMA Protection Worker learned from the probation officer that the male caregiver had missed too many classes to complete his counseling program and address issues of domestic violence and anger management.

October 4: Usma meets with caregivers again

On October 4 the Usma Supervisor and protection worker met with the caregivers to discuss the male caregiver's criminal record check and their future care of the child's brother. The Usma file note recorded the following:

> Reviewed Criminal Record Check. Re: criteria for Sec. 8 – [The male caregiver's] charges do not pose a problem with meeting this policy (using C.R.P.A.'s[10] schedule of offenses) and placement with caregivers. Discussed [the male caregiver's] recent assault charge and discussion with probation officer and her suggestion that he complete Life Line [counseling program]. [The male caregiver] agrees that completing this program would be beneficial. He will discuss it with his probation officer. He will notify our office upon completion so that this can be added to their file. [The caregivers] would like to continue with the Kith and Kin Agreement. [The brother] is feeling like part of the family. [The mother] and extended family members would like [the brother] to stay there as well. [The female caregiver] says her sisters and brother have noted changes in [the brother] (not as aggressive, open to affection, improved speech, ect.).

The Usma Supervisor's recollection was that in this meeting the caregivers came across as open about his troubled past and how it had affected their domestic life. This triggered concern about how the caregivers were coping with the tragedy of the child's death, more than concern about whether the remaining children in their home were in need of protection:

> ...We had received [the male caregiver's] criminal record check at that point, and so we then reviewed it with him again and cross-referenced it with the information he had given us in September. As well [the USMA Protection Worker] discussed the information she had gathered from the probation officer and the recommendations or suggestions that the probation officer had given [the USMA Protection Worker] to discuss with [the male caregiver].
>
> So in terms of the information that he gave us in September and the actual criminal record check, they coincided. He was quite accurate in his review of his own history. And they were very willing and involved and were wanting to continue with this process. They were being very upfront with us. I mean, given what had happened in the few weeks before this, they were managing and coping fairly well and were remaining committed to [the brother] and being very open with us.

Different perspectives of family and Usma

At the time of the investigation, the perspective of the family references and the children's maternal grandmother (the female caregiver's sister) was that the child, her brother and their family were failed by the child welfare system. The realization that the male caregiver, someone cared for within the family, could have hurt a child has been a very difficult one. Their view was that, both before and after September 4, important information was accessible to protection workers and not the family, and it should have resulted in the children not being placed or left with the male caregiver. The female caregiver's second brother (who with his wife has cared for the brother since March 2003) also felt strongly that the Usma Protection Workers were wrong to overlook him and his wife as an alternative to the caregivers as the appropriate kith and kin placement.

The Usma Protection Workers, on the other hand, felt that, both before and after September 4, the caregivers, family references and children's maternal grandmother

[10] This should have read "C.R.R.A.'s" in reference to the schedule of offences to the *Criminal Record Review Act* that were attached to MCFD's July 2002 Draft Practice Guideline for Kith and Kin Agreements under Section 8 of the CFCSA.

knew important information about the caregivers' history and suitability that they withheld from protection workers.

What seems clear is that members of the female caregiver's extended family did indeed know that the male caregiver's substance misuse and domestic violence had seriously affected the couple's family life in the past. However, they perceived that in recent months he had made progress with his addiction issues through involvement with elders, cultural activities and a counseling program. They were optimistic and trusting that the caregivers' personal and domestic dysfunctions were behind them. And they may have relied upon protection workers to know or foresee more about family members than did the family members themselves.

The Usma Protection Workers came to the kith and kin agreement from a positive perspective as well. The caregivers' family references were supported and they were received as such, with optimism and trust in the references' judgments that the caregivers' home was a suitable and safe one for the children. The protection workers' confidence in the kith and kin arrangement and the family references was reinforced by the female caregiver's relationship to Usma as a family support worker and by the fact that one of the caregivers' family references (the sister-in-law) was a fully delegated Usma protection worker.

The kith and kin agreement was premised on respect, in the absence of information to the contrary, for the healthy exercise of responsibility by parents and extended family. If protection workers concluded that the parents' choice of kith and kin caregivers was not suitable, or that it was no longer suitable, they would remove the children. The assumption of the policy, however, was that the role of the protection workers was to respect the parents' choice of kith and kin caregivers, so long as suitable caregivers were chosen, and not to seek out other family members for the task once the parents had made their decision clear.

District MCFD protection workers interview children and caregivers

September 25: Interview with eight-year-old daughter

On September 23 the MCFD Protection Worker assigned to the case attempted to interview the caregivers' eight-year-old daughter in the presence of her aid because the child was hearing impaired. It turned out that the child was not communicative with men and arrangements were made for a female protection worker to interview both the caregivers' daughters on September 25.

The one-page memo about the interview with the eight-year-old daughter described it as "not successful," although the eight-year-old had "worked very hard to try and answer my questions." The eight-year-old stated that neither of her parents ever got angry with her and that she and both the caregivers had been present when the brother pushed his sister down the stairs.[11] The interview then broke down when the eight-year-old started confusing the death of the child with a previous incident in which the caregivers' four-year-old daughter had fallen and broken her arm.

[11] The female caregiver and her eight-year-old daughter were known to have been at the grocery store when the male caregiver called 911 from the home.

September 25: Interview with four-year-old daughter

The one-page memo about the interview with the four-year-old daughter also indicated that it was unsuccessful, inasmuch as the four-year-old said that neither of her parents ever got angry with her and gave various versions of the brother pushing his sister down the stairs. First she said both the caregivers and their eight-year-old daughter were at home at the time and that the caregivers were sleeping at the time. Then she said both the caregivers were watching television in the room of the eight-year-old at the time. Then she said they were sleeping in that room.

Interpretation of interviews

The female MCFD protection worker's involvement in the case ended here. The information provided by the two daughters, as reported in the memos, was confusing, non-disclosing about abuse or distress of the children in their parents' care, and generally inconclusive. The MCFD Protection Worker assigned to the case nonetheless interpreted the non-disclosures of abuse or unhappiness as affirmative evidence of the safety and serenity of the caregivers' home in the entry on Intake 12 about the interviews:

> [The female protection worker] interviewed both [the eight and the four-year-old]. Neither...disclosed any fears about home or any violence in the home. Both describe the home environment as a safe and happy one. (See file for full interviews).

October 2: Home visit by MCFD Protection Worker

On October 2 the MCFD Protection Worker himself did a home visit with the caregivers in the presence of their children and the brother. His record of the visit on Intake 12 read as follows:

> ...explained needed to investigate the safety of the remaining children at the home based on the situation. And by interviewing all the children it could/has removed any doubt of a "likelihood" that the other children are at risk. I indicated that [the female MCFD protection worker] had spoken with the girls at school and they both express their happiness and a sense of safety in living at home. I discussed with [the female caregiver] concerns around her and [the male caregiver's] past hst. [The female caregiver] indicates that things between her and [the male caregiver] have been fine since they got back from treatment last Dec. We then talked about past domestic violence. [The female caregiver] says that the last incident occurred in the Spring of 2000.[12] [The male caregiver] indicates that things changed for the best since completing Kawasis treatment center when he quit drinking.
>
> [The male caregiver] talked about what has changed and how they as a family have healed. Again [the caregivers] indicated that the drinking and violence is in the past. Both says that their home is a home of culture and that they love children and have always opened thei: home to others. [The male caregiver] says that's why they took in [the two children in the kith and kin arrangement]....

[12] The most recent spousal assault had in fact happened in December 2001. The male caregiver had been convicted and served a short period of incarceration in the Spring of 2002 and was on probation for that offence to February 2003.

The entry on Intake 12 then moved to the male caregiver's account of the child's death on September 4. The MCFD Protection Worker later consulted the MCFD District Supervisor and recorded the following note:

> Still waiting for Coroner's report. Discussed the possibility of closing the intake as children express a sense of safety in the room and there appears to be no protection concern: re [the caregivers]. Speak with [USMA Protection Worker] about interviewing [the brother].

The MCFD Protection Worker also spoke with an Usma Protection Worker on October 2 and the Usma file note recorded the following:

> [The MCFD Protection Worker] has completed the interviews with [the female and the male caregiver] and the children. No safety or protection concerns. Said there was some discrepancy around who was home at the time of the incident (the children said [the female caregiver] was home), but also said that the girls were getting confused with the time one of the children broke their arm. The children had difficulties with dates and time-lines. [The MCFD Protection Worker] advised that [the brother] be interviewed by our [the MCFD] office. Will meet once [the brother] is interviewed.

October 4: Attempt to interview the brother

The MCFD Protection Worker attempted to interview the brother on October 4 and reported: "[The brother's] verbal skills are minimal. [The brother] could not answer any questions independently, he would just answer yes to each question or point to his trucks and [say] 'truck.'"

October 18: Further interview with four-year-old daughter

An October 18 Usma file note reported that one of the caregivers' children had disclosed that the brother was standing on his sister's chest before he pushed her down the stairs. On December 13, an Usma Protection Worker followed up on questions from the Coroner about the report, by interviewing the caregivers' four-year-old daughter. Sitting on the lap of her father, the male caregiver, the four-year-old daughter tearfully recounted how the brother had stepped on his sister's stomach and pushed her down the stairs.

October 2: District MCFD does immediate safety assessment

On October 2 the MCFD Protection Worker recorded on Intake 12 an immediate safety assessment of the children in the caregivers' home. (This is Risk Decision 3 in the MCFD risk assessment model.)

To assist this exercise, the MIS SWS intake format provided a list of fifteen "Safety Factor/Supporting Information" items that could be marked as "Yes," "No" or "Unknown," as well as an overall question "Children Safe?" In this assessment two of the items were marked "Unknown" and the rest were marked "No." The two items marked "Unknown" read as follows and for each the protection worker added his own note in upper case:

> 3. Parent has caused serious physical harm to the child OR has made a plausible threat that would result in physical harm to the child. (Unknown)
> INTAKE OPEN DUE TO DEATH OF INFANT IN THE HOME. CAUSE OF DEATH IS UNKNOWN. CONCERN OF PAST VIOLENCE IN THE [CAREGIVERS'] HOME.
> ...

5. Parent has previously harmed this OR any child, and the severity of the harm, OR the parent's prior response to the incident, suggests that the child's safety may be an immediate concern. (Unknown)
PAST HST. OF VIOLENCE IN THE HOME BY [THE MALE CAREGIVER].

Under the MCFD Risk Assessment Model, a "Yes" response to any item would be expected to trigger an overall response that the child was not safe, whereas "Unknown" responses might or might not trigger a not safe response. In this case, the immediate safety assessment question "Children Safe" was completed as "Yes." The result of characterizing the uncertainty around the child's death as "unknowns," that were then effectively given little or no weight in arriving at a "Children Safe" conclusion, was an unjustified default to optimism about the cause of the child's death. As the MCFD Protection Worker responded to questions in the investigation:

Q. Did you consider the indication that preliminary indications were that the death was inconsistent with a fall an unknown? Did you consider that nothing more than an unknown?

A. Yes and no. As I said, my first reaction was, That's not unknown, that's just not right. I want an explanation. And that's just my nature. I want an explanation....And what's happening is you're being told that, "No, you will know next week. The report is coming." Once the Coroner – that will explain everything. So you're told that this knowledge will come, but down the road. So you're asked to wait.

Q. Not to put too fine a point on it, you knew that indications were that the death was inconsistent with a fall.

A. Yes.

Q. So you knew that?

...

Q. That might change, depending on subsequent events, but that was known information. Its quality was what it was. That's what I am trying to get at.

A. I know. I sit there and I look back at that. But I think what was not known is, you could go two ways with that: you could go the sinister way, which – that's what happened, or the family tragedy way that there was something else to it, maybe she twisted on the fall or she went over the banister. So there are two ways of going about it. And everyone was telling us it was – like the family was telling us that it was a family tragedy, which makes sense if that's what they tell us. So when you get these reports of other people saying, "No, this family is really good. They've done wonders with [the deceased child]," it put weight to that family tragedy, that something more happened.

Q. That maybe there was a sensible explanation for first appearances that the death is in consistent with the story being given.

A. Yes. That's kind of what was starting to happen with the more – just where the weight was going, was people were kind of saying very positive things about [the caregivers], no one was entertaining the sinister side. So, okay, was there an explanation, then that it was –

Q. "No one" being like family, doctors?

A. Family, doctors. And, yes, I probably put a lot of weight on that. So it just kind of – it shifted a little bit more into the, Okay, it's unknown, but was it a family tragedy? And we're still waiting for the explanation on that. Okay, she fell down two flights of stairs or she went right over the banister. So you just – part of me – I hate to say this – part of me kind of hoped that was the case.

Q. Yes.

A. I mean the other thought is horrific.

Usma plans for expiry of kith and kin agreement on November 15

As October wore on the Usma Supervisor and protection workers knew that they had a looming decision to make about whether to continue the placement of the child's brother with the caregivers after the expiry of the kith and kin agreement on November 15. This was a voluntary arrangement that the parents or the caregivers could end or choose not to renew. Usma's particular concerns were that the child's death might cause the mother to want the brother back with her or might cause the caregivers to be uncomfortable about continuing to care for him. There was also the question of the outcome of MCFD's investigation into the safety of the caregivers' home following the tragic death.

Usma and family support continuation of kith and kin

Usma's October 4 meeting with the caregivers had explored with the caregivers whether they wished to continue to provide a home for the brother. The answer had been yes. Extended family members were understood to also support the brother continuing to stay with the caregivers.

On October 22 an Usma Protection Worker entered the following file record of her consultation with the Usma Supervisor about the expiry of the kith and kin agreement:

> ...Will meet parents and extend the agreement. If parents are not in agreement, we will remove [the brother] – risk factors [with his parents] have not been addressed. Reviewed [the brother's] continued progress in the [caregivers'] home (increased speech; behaviour not as aggressive). He has had limited contact with his parents. They are very difficult to contact. Informed supervisor that [the parents] are believed to be reunited.

October 24–25: Usma seeks and MCFD discusses funding of kith and kin

The Usma Protection Worker also entered a file note of a further consultation with the Usma Supervisor on October 24:

> ...[The Usma Supervisor] will arrange meeting with [the MCFD District Supervisor] to discuss the kith and kin agreement and provide all paper work that they need to open a file (risk assessment, letters of reference and criminal record checks).
>
> Will continue with kith and kin agreement. Discussed expiry on November 15, 2002. Will need to renew agreement. If parents are not in agreement or cannot meet before this date, will have to remove [the brother] – protection concerns [with his parents] have not been addressed.

On that same day the Usma Supervisor emailed the MCFD District Supervisor to discuss planning for the kith and kin agreement. Her message said that Usma had "completed all the assessment of the home and plan and are wanting to proceed with finalizing the funding arrangement with your [the MCFD] office." The Usma Protection Worker and the MCFD Protection Worker also had a meeting about the case on October 24.

Around this time, there were also emails passing between MCFD management about who should and could pay for the kith and kin agreement. In discussion with the Usma Supervisor in August, the MCFD District Supervisor had agreed to consider MCFD funding for the kith and kin agreement. This was an issue because the federal government funding for child welfare services provided by Aboriginal agencies was tied to the child being in care; out-of-care options (which a kith and kin agreement was) were not federally funded.

An October 25 email from the Aboriginal Services Practice Analyst posed the following for discussion:

> Another element of the section 8 saga. At this time, the Federal Government is on record as not being willing to fund for the care of children who are not in care. Neither the Province, nor the Region, nor a Delegated Agency can bill Canada for the care of a child who is the subject of a section 8 agreement. I believe that this was unanticipated by those who developed policy for section 8.
>
> So, in order for the Province not to be in contravention of section 25 of the Constitution, I believe that it is the Province's obligation to fund CFCSA section 8 agreements, including those made on the behalf of on-reserve residents. Exactly what the mechanisms are for this process to occur are, I don't know, but I believe the people in Financial Services Branch might be able to give some insight.
>
> These comments are intended only as context for discussion, and is only just my personal awareness of this matter – I realize that I may not be reflecting the entire picture here.
>
> I hope that helps somewhat, although it may raise more questions than it answers.

This email was forwarded to the MCFD District Supervisor, who immediately responded as follows:

> I was aware of [the practice analyst's] information.
>
> This puts us right back to finding out from Financial Services how this shortfall in the act can be accommodated.
>
> My simple solution of locally paying for the sec 8 will resolve the issue faster than asking Financial Services to come up with a provincial solution….but would be pleased if you could direct the problem to them and hope they can come up with a workable negotiation within a reasonable time-frame.
>
> So…who directs this issue to Financial Services for a solution?

October 25: Aboriginal Services Executive Director and Deputy Director discuss funding issue and question continued placement

In two further October 25 emails both the Executive Director, Aboriginal Services and the Deputy Director, Aboriginal Services, quite apart from the funding issue, questioned the wisdom of a placement with the caregivers. The Executive Director, Aboriginal Services

emailed the Regional Director with his point of view:

> I don't agree with all of [the Aboriginal Services Practice Analyst's] analysis, but he is right in saying that the Feds won't pay for S.8 placements. We, on the other hand, should not leap in to fill the void as we'll never get out of paying. This is one of the issues I will be taking up with DIAND when I'm in Ottawa next week. *As to this particular case, I am a bit worried that anybody would agree to a placement in the same home while the [Director's case] review is pending.* [emphasis added]

The Deputy Director, Aboriginal Services emailed the Aboriginal Services Practice Analyst and the Regional Assistant Director with her point of view:

> Re: kith and kin. There have been a number of discussions regarding section 8 and funding by DIAND at the First Nations Directors partnership meeting. This has not been resolved formally with the Federal government. DIAND reps for BC have stated they will fund section 8 agreements if they receive a billing from the agency. They have not put this in writing so the agencies are likely skeptical, however, they should still bill DIAND. I am assuming the billing would have the same qualifications around it as a CIC [child in care] placement with respect to billable to DIAND and residence of the child at the time of (removal). (this is probably more info than you want [Regional Assistant Director]). There has also been no ability/ agreement for the ministry to bill DIAND for k&k at this point. This is still under discussion and is at the Federal/Provincial level. In the meantime, the ministry has not made any commitment to the agencies to fund them for k&k for children that would be billable to DIAND if they came into care. Nonetheless the ministry should not be using this as a deterant [sic] to utilizing k&k with Aboriginal children regardless of whether they are billable to DIAND or not if they came into care.
>
> My suggestion to the region is: as the agency if they have attempted to bill DIAND. *This also begs the larger question that we were just getting into at our meeting. Given what we know now about this family, would you place children in this home on a k&k? If no, why would you agree to fund it?* [emphasis added]

No funding was ever provided for the kith and kin agreement. And these emails with MCFD management's views about the prudence of even considering the placement did not get passed on to the MCFD district office or Usma.

Background: The relationship between MCFD (Aboriginal Services) and Usma

The relationship between MCFD and delegated Aboriginal agencies is complex, and was in 2002–03.

Delegated provincial authority, partnership and Aboriginal autonomy

The terms of the 1985 agreement between the NTC and the provincial Superintendent of Family and Child Services were clear that NTC workers with delegated authority relating to family and protection services under the *Child and Family Service Act* were subject to the direction of the Superintendent (later the Provincial Director under the CFCSA with responsibility for delegation to Aboriginal agencies). Historically however some First Nations in British Columbia had questioned the authority of the provincial government over them in child welfare

matters. As nations, they believed that they should be dealing nation-to-nation, which meant to some, with the federal not the provincial government. This clash in perspectives about jurisdiction had caused tensions between delegated Aboriginal agencies and MCFD Aboriginal Services. In that context, Usma was not considered by MCFD to be a "difficult" agency. Usma understood that in child protection matters, it was acting with delegated authority from the Provincial Director under the CFCSA.

In September 2002 the provincial government and leaders of the Aboriginal communities in British Columbia had signed an historic memorandum of understanding that recognized a partnership between them to reduce the number of Aboriginal children taken into government care. In the fall of 2002, there was a strong sense in the MCFD headquarters and elsewhere in MCFD and among Aboriginal leaders in BC, that this was an important moment for BC's child welfare system as it related to Aboriginal children. MCFD leadership placed a high value on respecting Aboriginal communities and encouraging their increased autonomy in making decisions about their children.

MCFD headquarters organizational factor

Some features of the organizational structure of MCFD headquarters and the management style of the Provincial Director under the CFCSA were also relevant to MCFD's relationship with Usma.

The Provincial Director under the CFCSA was also the MCFD Assistant Deputy Minister responsible for the Children and Family Development Division, which included the Aboriginal Services branch. Aboriginal Services had responsibility, amongst other things, for practice support to Aboriginal agencies. The Executive Director, Aboriginal Services, though not an assistant deputy minister, reported directly to the Deputy Minister and was a member of the MCFD Executive.

The Deputy Director, Aboriginal Services was the number two manager in Aboriginal Services, where she had supervisory responsibility for the practice analysts. She was also the provincial Deputy Director under the CFCSA (with the same responsibility as the Provincial Director for Aboriginal children living on reserve). She thus had a dual reporting relationship to the Executive Director, Aboriginal Services and to the Provincial Director and, unlike the Executive Director, Aboriginal Services, she had fully delegated authority under the CFCSA.

The Deputy Director, Aboriginal Services was away on annual vacation on September 5, 2002 when Usma, as required, reported the child's death to the Provincial Director. She returned to work on October 1. The Executive Director, Aboriginal Services was an experienced manager and former field social worker, but his position did not carry delegated authority under the CFCSA. Instead an Aboriginal Services Practice Analyst, who did carry delegated authority under the CFCSA, but was not a manager, was acting for the Deputy Director, Aboriginal Services when she was away on vacation. While in that acting position, this practice analyst, like the Deputy Director, Aboriginal Services reported to the Provincial Director, and not the Executive Director, Aboriginal Services on matters concerning delegated authority under the CFCSA. This practice analyst had had a full, integrated caseload as a registered social worker for nine years, before moving into an accounting career as a finance manager, then returning to MCFD as a practice analyst. He was qualified to

act for the Deputy Director, Aboriginal Services. The Executive Director, Aboriginal Services nonetheless had the superior skill set and management experience to provide leadership in this case. However he did not have the express authority to do so under the MCFD management structure.

The Aboriginal Services Practice Analyst who was acting for the Deputy Director, Aboriginal Services in September, and the Deputy Director, Aboriginal Services herself after she returned to work on October 1, met with and verbally briefed the Provincial Director about this case from time to time. The Provincial Director believed that the best judgment in individual cases rested with local protection workers and supervisors. He applied a very hands off approach to case management generally and in this case.

Aboriginal Services and Quality Assurance were separate branches of the Children and Family Development Division. The managers and practice analysts in Quality Assurance were all fully delegated for protection work under the CFCSA and they dealt with critical incident reports on a very regular basis and with deputy Director's and Director's case reviews. The Aboriginal Services Practice Analyst to whom this case was assigned at MCFD headquarters from September 9 on did not have this level of experience with critical incidents or case reviews and had had no previous involvement with a child death case or with the Coroners Service.

Relationship between Usma and Aboriginal Services in 2002

In 2002, Usma was considered to be one of the more established Aboriginal agencies. There had not been much interaction required between Aboriginal Services and Usma. From the point of view of Aboriginal Services this was a good sign.

Aboriginal Services officials (indeed all MCFD headquarters' officials) were sensitive to, even preoccupied with, the need to be respectful of Usma's autonomy in terms of cultural appropriateness and the practice decisions of its protection workers. This was no doubt partly a function of the intended direction, which at the time had been made very express by MCFD provincial leadership, of building confidence within the Aboriginal child welfare community. The result of this heightened sensitivity was that Aboriginal Services officials, despite being responsible for the delegation of authority to Usma under the CFCSA, were in the course of this case intensely concerned about being perceived by Usma to be too directional.

The Usma Director and Supervisor were well aware that the Provincial Director under the CFCSA could if necessary give directions to Usma through the 1985 agreement and the delegations of authority under the CFCSA to Usma Protection Workers. At the same time they also certainly expected respect and sensitivity for Usma's role as an Aboriginal child welfare agency and for the practice judgments of its protection workers.

Kith and kin agreements and the tragedy of the death of a child placed under such an agreement were uncharted waters for both MCFD and Usma. The Usma Director, Supervisor and protection workers were looking for guidance and assistance from Aboriginal Services and for a cooperative joint working relationship with the MCFD district office. They told this investigation that they were not opposed to Aboriginal Services' direction on the handling of the case if accompanied by reasons that they could understand. Far from being wrapped up in maintaining autonomy as an

Aboriginal agency it was apparent to the investigation that Usma would have received informed and clear external advice or direction around this case with gratitude and relief. As the Usma Director said:

> I don't think some – a team of people coming from somewhere that were there to help would ever be viewed as anything but helpful. It's having access to that kind of information that would be really useful.

October 28: Deputy Director Aboriginal Services and Usma Supervisor discuss wisdom of renewal of kith and kin agreement

On October 28 the Usma Supervisor was again consulted by the Usma Protection Worker about planning for the brother, and entered the following file note:

> Discussed planning for [the brother]. The Sec. 8 agreement expires in a couple of weeks and [the Usma Protection Worker] wanted to know what plan we are proceeding with. We reviewed the current issues in the case and decided that the plan would be to renew the Sec. 8 and if [the USMA Protection Worker] is unable to locate the parents or they are unwilling to renew the agreement then we would plan to remove [the brother]. I agreed to contact [the Aboriginal Services Practice Analyst] to discuss with him how to renew the agreement.

The Usma Supervisor then left a detailed voice message with the Aboriginal Services Practice Analyst asking him to call to discuss with her how to renew the kith and kin agreement. Still later in the day, her call was returned by the Deputy Director, Aboriginal Services and the Aboriginal Services Practice Analyst together, in which the Deputy Director, Aboriginal Services questioned the wisdom of renewal the kith and kin agreement.

This telephone call between the Deputy Director, Aboriginal Services (with the Aboriginal Services Practice Analyst) and the Usma Supervisor about the management of the brother's case was a critical one for the case. If an MCFD record of the call was made it was not preserved in the materials available to the investigation; however, the Usma Supervisor made a file note at the time and both she and the Deputy Director, Aboriginal Services remembered the call.

The call was consternating for both Aboriginal Services and Usma.

Deputy Director's knowledge of the case

By the end of October, the Aboriginal Services Practice Analyst assigned to the case since September 9 had given, at a minimum, a verbal briefing about the case to the Deputy Director, Aboriginal Services, who had returned from vacation on October 1. She had reviewed excerpts from the Usma files on the protection concerns that had triggered the placement of the child and her brother with the caregivers. She had also reviewed the MIS SWS print-out on the eleven historical intakes on the caregivers (some forty pages). She had not seen the MCFD paper file on the caregivers with its supplementary information, particularly on the 1998 intake; however, it is quite possible, if not probable, that she had reviewed what was entered so far onto MIS SWS for Intake 12, the district MCFD's still open investigation into the safety of children in the caregivers' home. She had also learned from the Aboriginal Services Practice Analyst that Usma intended to extend the

brother's kith and kin placement with the caregivers and, based on what she knew, she was concerned about whether that was in his best interests.

Usma Supervisor's perspective on the call

The Usma Supervisor had never before spoken with the Deputy Director, Aboriginal Services or been contacted about a case by anyone of her seniority at MCFD. The Deputy Director, Aboriginal Services's telephone call to discuss a specific practice decision was therefore unusual and surprising for the Usma Supervisor, and the Usma Protection Workers with whom the Usma Supervisor spoke soon after the call.

It was clear to the Usma Supervisor that the Deputy Director, Aboriginal Services was seriously trying to dissuade Usma from continuing the brother's placement with the caregivers. She was surprised that the Deputy Director, Aboriginal Services had not contacted the Usma Director. She was concerned that the Deputy Director, Aboriginal Services appeared to be questioning her practice judgment for reasons, she suspected, that the Deputy Director, Aboriginal Services was not sharing.

The Usma file record of the telephone conversation read as follows:

> ...[the Deputy Director, Aboriginal Services] wanted to discuss my case plan to renew the Sec. 8 agreement and whether or not this was in [the brother's] best interest. She asked if I had thoroughly reviewed all the information on [the caregivers] and felt confident in my decision. I explained that [an USMA Protection Worker] and I had reviewed [the male caregiver's] criminal history with him, reviewed their prior contact with MCFD with both of them [the caregivers], PA MCFD has investigated their home and found no current protection concerns and [the USMA Protection Worker] has spoken to [the male caregiver's] PO and confirmed that he is meeting all expectations of his probation order. [The Deputy Director] said that a number of red flags have come up upon her reviewing the file material herself and they are: That [the male caregiver] is currently on probation for assault of [the female caregiver], that there is an unresolved allegation of assault on his own child (from 1998) and the unresolved death of [the child]. We discussed her concerns and I said that I felt that all the information had been checked out and I feel this home is a safe placement for [the brother]. [The Deputy Director] said that the questions she is asking are ones that I am going to have to answer in the Director's review. I asked her if she had information on the cause of death from the Coroner that I wasn't aware of yet. She said she did not have any new information from the Coroner. She asked if it would be more appropriate to do a further study on the home to document more thoroughly their information and I said that if we could not approve them based on what we know already then I didn't see the purpose for the study. She asked if we could move [the brother] to an approved resource and I said that we couldn't do that unless we remove him [into the custody of the Director under the CFCSA]. She asked if this plan is in [the brother's] best interest and I said that I think it is. She said that she questions the adequacy of the supervision in the home and why, if there was fighting between the kids that night, did an adult not intervene, is there a child's gate on the stairs. I told her that I would review the file information again and call her once I have done so. [The Deputy Director] stated that she does think that this plan is in [the brother's] best interest.[13]

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[13] The Usma Supervisor explained to the investigation that the Deputy Director, Aboriginal Services did not say that placement with the caregiver was in the brother's best interest; this sentence instead referred to it being in the brother's best interest for Usma to go back and again review the information and planning for him.

Deputy Director's perspective

The Deputy Director, Aboriginal Services had made the call because she and the practice analyst were concerned that the Usma Supervisor did not know what she needed to know about the death of the child. At the same time, the Deputy Director was uneasy about giving Usma information that she understood the Coroner did not want to be disclosed. She was also concerned about misleading the Usma Supervisor and, though the Deputy Director had delegation authority over Usma under the CFCSA, she was reluctant to direct an Usma case practice decision.

The Deputy Director thought that the solution to the dilemma presented by MCFD's possession of information from the Coroner that Usma did not have was for the Coroner himself to provide that information to Usma. Then Usma would be able to make an informed decision about the brother's placement with the caregivers.

Message intended by silence; different message received

The Deputy Director's recollection was that she consciously remained silent in response to the Usma Supervisor's question about whether Aboriginal Services had information about the child's death that Usma did not have. Then she encouraged the Usma Supervisor to directly contact the Coroner. The Deputy Director thought that by not answering the Usma Supervisor's question, and instead suggesting that she deal with the Coroner directly, the problem would get solved without disclosing that MCFD had received information that it was told not to share, and had not shared, with Usma.

The Usma Supervisor got a different message from her conversation with the Deputy Director. She understood the Deputy Director's silence to be her reassurance that Aboriginal Services was not withholding information from Usma. Yet the Usma Supervisor still came away feeling uneasy about whether Usma had as much information about the child's death as did Aboriginal Services, and she was at loss to know what more was out there. As the Usma Supervisor recalled:

> **Q.** Did you find the level of directiveness in her way of communicating unsettling or disquieting?
>
> **A.** I did. I believe that she wanted me to remove him and I said that I didn't feel comfortable – I didn't feel that we had the evidence to go into court. We talked – I could have gone in on a likelihood and that there was this outstanding issue of [the child's] death.
>
> And when I went through each point, I didn't believe that those issues were unresolved. [The child's] death, we were waiting – it wasn't unresolved. It was still being investigated. We were waiting for – I wouldn't consider it to be unresolved because we hadn't gotten to the point of it being resolved yet. And my knowledge of the 1998 investigation on the death of their own child, it was resolved. It was a completed, closed investigation. I didn't consider that to be unresolved. And, yes, I was aware that [the male caregiver] was on probation for assault of [the female caregiver]. Was there something more that I should have known.
>
> All these three points that she was raising, I didn't have anything to – any way to understand why she was raising it, and she didn't provide me with any more information. And that's why I asked her, did she know something more, and she said no.

Usma Director's involvement with the call

It is not entirely clear whether the Usma Director was also a participant in this telephone conversation with Aboriginal Services. The Deputy Director, Aboriginal Services thought the Usma Director was a participant. The Usma Director thought she may have been present in the Usma Supervisor's office but that the call was not on a speakerphone. The Usma file note and the Usma Supervisor's recollection were that the Usma Director did not participate in the October 28 call, but that the Usma Supervisor and Usma Director met the next day to discuss the matter. An Usma file record for October 29 indicated that the Usma Director agreed, "that based on the information that we are aware of and the subsequent MCFD investigation, that the plan is in [the brother's] best interest to remain in [the caregivers'] home. [The Usma Director] will participate in the telephone discussion with [the Deputy Director, Aboriginal Services] tomorrow." There was no file note of a follow-up telephone conversation on October 30.

The Usma Director recalled agreeing with the Usma Supervisor that, if Aboriginal Services had concerns about the brother's placement with the caregivers, it should be providing Usma with specific information in that regard. She also thought she may have asked the Usma Supervisor to request the Deputy Director, Aboriginal Services to put her concerns in writing. There is no record of correspondence between Aboriginal Services and Usma on this issue, but the Usma Supervisor did recall:

> - it was our position that if she [the Deputy Director, Aboriginal Services] wanted to pursue her line of thinking, that we wanted her to put that in writing to us so that we could – if we were going to remove him [the brother] based on some of her concerns, that we were going to use that as supporting evidence, supporting documentation for that.

October 29: Usma Supervisor and MCFD District Supervisor meet to discuss case

The Usma Supervisor and MCFD District Supervisor met on October 29. Usma had to complete its case planning for the brother and the information MCFD had obtained in its investigation of the safety of the caregiver's home was obviously an important part of that planning.

According to the Usma file note, the Usma Supervisor learned from the MCFD District Supervisor that:

> - to date - his investigation is waiting to be signed off – no protection concerns found – kids did not indicate any fear of parents, no disclosure of drinking or violence by either parent, no disclosure or awareness of dad's assault on mom.

They discussed the MCFD historical intakes on the caregivers, including whether the 1998 intake on the family and a 1999/2000 report about the caregivers' drinking might not have been completed properly by Nanaimo MCFD; but that there was now no fear of the male caregiver by his children or disclosures by the children concerning their parents' drinking.

The Usma Supervisor told the MCFD District Supervisor about her telephone call the day before from the Deputy Director, Aboriginal Services and recalled that he was very supportive of the position she had taken in the call. The Usma Supervisor again had no idea that the MCFD District Supervisor himself had been directed to withhold from Usma

information about the details of the child's injuries and whether they could be attributed to falling down some steps.

October 30–31: Coroner gives further information to Usma Supervisor and requests that it be kept confidential

On October 30 the Usma Supervisor called the Coroner for an update. The Coroner reported that the pathologist's investigation was not yet completed and assured the Usma Supervisor that he would call once he heard anything. The Coroner's file also recorded:

> - [the brother] still in foster care [with the caregivers]
> - monitoring [the brother] closely – no action until result of autopsy

The next day the Aboriginal Services Practice Analyst called the Coroner. They discussed the Director's case review that was being done around the child's death and that Usma was renewing the brother's placement with the caregivers. The Aboriginal Services Practice Analyst asked the Coroner if, in the words of the Coroner's file note, it "would be possible to share [the child's] injuries with [the Usma Supervisor] who has to make decision to renew [the kith and kin] agreement." The Coroner called the regional coroner, and then added the following note on his file:

> - OK to talk to [Usma Supervisor]
> - stress "preliminary autopsy subject to change"
> - err on side of caution!

The Coroner reported to the Aboriginal Services Practice Analyst that as a result of his conversation with the regional coroner he would be providing information in the interim autopsy report to the Usma Supervisor. The Coroner's recollection was that this would also have been the first time that he provided details of the child's injuries to the Aboriginal Services Practice Analyst. (The Aboriginal Services Practice Analyst's recollection was that he had received details of the child's injuries from the Coroner on September 10.)

The Coroner then called the Usma Supervisor and recorded the following on his file:

> Called [Usma Supervisor] & requested info to be kept confidential & that information given are only preliminary autopsy findings & are subject to change.
> - info passed on & assurances received to confidentiality & will discuss further with [the Aboriginal Services Practice Analyst]

The Coroner's perspective on this October 31 call was that, as requested by the Aboriginal Services Practice Analyst and as authorized by the regional coroner, he provided the preliminary autopsy results to the Usma Supervisor to assist Usma in carrying out its child protection responsibilities. As he told the investigation:

> **A.** Well, I did my thing by informing them what I did when I did, and you know, I knew something was going on in the background but that is not part of my investigation or my work, so to speak. I knew there was something going on in the background because, one, I got call from [the Port Alberni Family Physician] looking for some information. I got a call from [the Aboriginal Services Practice Analyst], and we did tell [the Usma Supervisor] verbally the preliminary autopsy form C results.

...

So like I say, that is their work. I asked by [the Aboriginal Services Practice Analyst], because there was a decision to be made – we co-operated fully with that. You know even though it was done verbally I think she had enough information to do whatever decisions, and I wasn't going to get into an argument or get involved with that particular decision, so I am still waiting for the final autopsy results.

Q. Did you put your mind to that, or you were beyond that; you thought that was that? I have done my job. It is not my job?

A. Well, it's not my job to be phoning Usma or MCFD, is that kid out of the house yet?

Q. No, no. I mean –

A. That is their decision. They obviously assess or they are supposed to assess, or that's part of their job to assess – I should put it that way maybe – what the situation is and what actions to take. That has nothing to do with the Coroners Service.

The Usma Supervisor recalled the conversation as friendly and matter of fact, but also limited in that the Coroner said the regional coroner had directed him to provide information in the interim autopsy report to Usma, he was doing what he had been told to do, and he was not going to do anything more than that. The Coroner proceeded to read the information over the phone. The Usma Supervisor wrote it down as quickly as she could on "sticky" note slips of paper, but she recorded nothing in the Usma case file. As she explained:

Q. Your conversation with [the Coroner] on the 31st is not in the contact notes or in the Usma files, right?

A. That's right.

Q. Why is that?

A. It is because he directed me to not record it in any formal capacity on a file as it was not the official autopsy results, it was only preliminary autopsy results. And because they were not the official record, I was not to record it.

Q. Had anyone ever asked you to do anything like that before?

A. No.

Q. First of all, how did you feel internally about that and how did you respond, if you did, in any way to [the Coroner] about why he would ask you to do something like that?

A. I had no way of knowing that this is how the coroners office works or anything like that. So I asked him, "How am I supposed to use this information?" once he gave it to me. He was not prepared to give me an opinion on how I could use it. He was just told to give it to me so that I could use it for my planning for [the brother]. So I questioned, "How do I use this information if I'm not actually allowed to use it in discussions with anybody or can't document it on the file or put it in court documents or discuss it with caregivers or anything like that?" And he was not prepared or able – it wasn't he was being difficult. He was told to give me the information. He wasn't to interpret it and he wasn't to sort of elaborate on it or give me any explanation. He was just to give it to me.

...

Q. You wrote on some sticky notes?

A. I grabbed whatever I had in front of me, and I just started writing, because I didn't know he was going to provide me with such an amount of information, and I wanted to have it – in case something came forward that I could use this, I wanted to have some way to reference it back to this October 31 phone call.

Q. So when he asked you not to document that information, did you take that to mean you weren't even supposed to be writing it on the stickies?

A. Yes.

Q. But you did it anyway because it was the right thing to do?

A. It just seemed like pretty significant information to me. Again, this phone call, these series of phone calls between October 28, and then me calling the Coroner and him saying nothing and the next day I get this amount of information, I just felt I had to write it down. I wanted to have it in case something further came up.

Q. Do you know whether he knew you were actually writing anything down?

A. No, I don't. I didn't tell him.

The information the Usma Supervisor recorded on the "sticky" notes from the Coroner's call read as follows:

- has had long discussions with [the Aboriginal Services Practice Analyst] & regional Coroner
preliminary report – by [the pathologist]
evidence of head trauma
inc. scalp contusions
subdural hamorrage
(sml. volume)
sml. forcio of sub-brachnoid
hem
- no skull fracture
- eyes returned
- brain & spinal
cord still retained
- could be consistent with fall – still
questionable.
evidence of blunt
thoracic/abdominal
trauma inc.
a) bi-lateral non-
displaced lateral
rib fractures some
with callus formation
b) mesentric &
retroperitoneal
lacerations with
hemoperitneum
(some of intestines
torn away from

lining of stomach)
(45 ml of blood)
c) sub-capsular
contusions &
small lacerations of liver
d) sml. epicardial
contussions of
posterior rt.
atrium (heart)
no evidence of
sig. pre-existing
nat. disease.
- told [the Usma Director]
- Sept – other injuries
not consistent with the fall.

This information was not quite the same as the September 11 briefing note circulated at MCFD headquarters, in that the Usma Supervisor's notes said "could be consistent with fall – still questionable" and "Sept – other injuries not consistent with the fall," whereas the September 11 briefing note said "preliminary autopsy results indicate injuries not consistent with the explanation given by the caregiver." The HARC physicians explained the distinctions in the language used:

> The briefing note…is very clear that the cause of death is alarming. As a physician, there is a little bit more doubt about the cause of death in the set of sticky notes. But as a physician reading all the other information on the sticky notes, with all the other injuries listed, it's still clear to me that the cause of death is not consistent with a fall.
> As a social worker, not knowing how to interpret all the medical information, I think that [the Usma Supervisor's] sticky note messages introduce more doubt as to the cause of death, whereas…the briefing note, is a lot more clear.
> …
> I agree that as a physician, if I would have read all of those injuries as detailed by [the Usma Supervisor] on her sticky notes, that I would have certainly have been questioning her statement, "Could be consistent with fall – still questionable."

The Usma Supervisor did not have the medical knowledge to interpret or properly understand the significance of the child's injuries described by the Coroner and she did not know whether they could have happened in a fall down a few steps. She came away from her conversation with the Coroner believing, still, that there had indeed been a fall down some steps; and understanding the child's injuries could be consistent with the fall and that the "other injuries" not consistent with the fall were the healing rib fractures, which she thought were pre-placement injuries.

One snippet of the Usma Supervisor's "sticky" notes read: "told [Usma Director]." The Usma Supervisor's recollection was that in the call the Coroner:

> **A.** …stated that he had told [the Usma Director] in September that there were other injuries that were not consistent with the fall, and then he went on to provide me with the details of the preliminary report by [the pathologist]…
>
> **Q.** Let's deal with that first statement there. "He said he told [the Usma Director] in September that there were other injuries that were not consistent with a fall."

A. I asked him that. I never heard that there was – anything about this before. And he just said that he gave her – he would not go into any description about anything –any information he gave me on this phone call. He just said, "I told her some other information in September." So I said, "Well, I guess I'll have to ask [the Usma Director] about that meeting that you gave her information about this."

Q. You may not have had enougn information to even think about this, but what, if anything, did you think there were "other injuries that were not consistent with the fall," what did that mean? And I don't mean to details injuries if you don't know them, but what did that statement mean?

A. I didn't know what that meant. The only injuries I was aware of were the rib fractures. We learned that on the 20th of September. I didn't know if that's what he was referring to.

Q. Did you understand that statement to mean that there were injuries indicating that her death was not consistent with a fall down stairs?

A. I can't say that. I had nothing to sort of refer to make that sort of decision or to have those kinds of thoughts.

Q. Would you agree that it's one thing to say that if you have healing ribs that you got three weeks earlier, those were injuries that were not from a fall down stairs? Not consistent with falling down stairs is different from the idea of having injuries that are inconsistent with having fallen down stairs at all or having died from taking a fall down stairs.

A. He didn't say that the injuries were inconsistent with her death from a fall down the stairs. It was just inconsistent with a fall. Because I knew about the rib fractures, then that sort of – I won't say confirmed but the thought that I had that this may be pre-placement injuries related to the mother. So he didn't say that and I didn't have any other – I had a piece of information that there were old, healing rib fractures. The he says this, that there were injuries that were not consistent with a fall. My thought is that those old rib fractures are from pre-placement or not from the caregivers. So that's what I thought possibly he was referring to. But because he won't give me any information about that, I had to ask [the Usma Director] about that.

Right around this time the Usma Director was starting an unrelated leave from work. Her recollection was that by October 31 she was gone from the Usma office and did not take part in the call to the Coroner or discuss the call with the Usma Supervisor.

The Usma Supervisor's recollection was different; that after discussing her conversation with the Coroner with the Usma Protection Workers, she met with the Usma Director and showed her the "sticky" notes of what the Coroner had said. In the Usma Supervisor's recollection:

Q. So you had said you did talk to your colleagues about the information that he gave you.

A. I did. I didn't go into – I didn't go into detail of the specific injuries, but I did say that I received information that – and the [the Usma Director] had been told of other injuries not consistent with a fall, that there was evidence of injuries to her brain, internal injuries, as well as there is this point that he raised that it could still be consistent with a fall, it's still questionable.

So we tried to understand how we were to use this. And given that the – it wasn't the

final autopsy results, they were still waiting for the timelines, all these outstanding questions, we just couldn't sort of reconcile this information with what we also – we were being told that it was okay, that she had died from a fall down the stairs. No one was able to kind of fit this together for us.

So then I discussed it with [the Usma Director], I did raise the point that he had said he had told her there were other injuries not consistent with a fall in September, and she said that he didn't provide her with any information to that effect. So I asked [the Usma Director] to – we reviewed it. And because I was very concerned about having this information and not sure how to use it, and [the Usma Director] stated she would be following up with [the Deputy Director, Aboriginal Services] on this as part of this response to the 28th call, October 28 phone call.

And the outcome of my discussion with [the Usma Director] was that we had this information, but at this point we were going to proceed with the plan that we had. We had no other way of – I mean, unless I had gone – I went and discussed it with an outside source, which was something I was not – I was told not to do. I couldn't consult with anybody outside our office on this.

The Coroner has maintained to the investigation that he told the Usma Supervisor that the information he was giving her was confidential and not to be made public, but he never said she could not commit it to paper or disclose or use it in her work. The Usma Supervisor, on the other hand, understood the Coroner to tell her that she could use the information in planning, but it was too sensitive and uncertain to be officially recorded by her or disclosed by her. As a result, the Usma Supervisor understood the Coroner's stipulations about the information being confidential and preliminary to mean that it was too sensitive and uncertain to be relied upon for child protection purposes or to be disclosed to anyone, including the MCFD District Supervisor. As a result, she retained her handwritten "sticky" notes of the October 31 call with the Coroner separately in her office; discussed them with no one except her Usma colleagues; and never recorded the information they contained in the Usma case file system.

The situation was an unprecedented and entirely unsatisfactory one for the Usma Supervisor, who:

A. …sat at my desk and looked at these sticky notes and thought, what am I going to do with this? It just – between the 28th and the 31st I was sort of in a – I felt very confused, I felt pressured. I didn't know what to make of this information. It was not something I was prepared to interpret on my own. I needed someone to interpret it for me. And the person who was giving it to me, the Coroner, was not willing to do that, and he also had instructed me not to discuss it with anybody. So I didn't know what to do with it. It left me in quite a dilemma.

So he also then says that it still could be consistent with a fall. So I didn't know what to make of – they were still waiting for the timeline of the injuries. That was still a significant piece to this, as to the timing of all these injuries…."Could be consistent with fall, still questionable,"…

Q. I see.

A. So then I didn't know, was this – were these injuries related to a fall, were they typical of a fall. And yet they were still waiting for the timeline of the injuries, and still the rib fractures – the information on that had not come in yet in terms of the timing on that. So I didn't know if this was injuries as a result – at the time of her death or sometime

before that or anything like that. I didn't know how to use this information....

This unofficial, uncertain and undocumented manner of communicating important and medically technical information about the case was highly problematic for the Usma Supervisor:

> ...I have the coroners office who is also coming from the regional coroner giving me this direction, I'm abiding by their direction. I don't know if this is standard or not. [The Coroner] does say that it's unusual for them to release preliminary autopsy results, but then they're not considered the official autopsy results, the final ones. So they are subject to, I guess, change or updating. And certainly because they're waiting for the timeline of the injuries, that hadn't come in yet. And he was not providing this to me in writing, like this was over a phone call. And so there is nothing I could get that I could use in terms of documentation.
>
> ...
>
> ...I didn't see this as like a child protection report he was making. So I guess I didn't apply the sort of – that rule to this. This was information that was just outside my realm of experience, or our whole office's experience, and it sounded like it was outside the norm for at least the local Coroner. I don't know if the regional coroner, this is how they had done things, but certainly for the local Coroner.

The Usma Supervisor and protection workers discussed their need for HARC or a local physician to help them interpret the information from the Coroner, but they thought that was precluded:

> ...given that [the Coroner] had directed me to not record – that it was not information that I could discuss with anybody and it was not official autopsy results, I didn't feel that I had any choice but to not take it outside our office.

She said nothing to the MCFD District Supervisor about what the Coroner had told her, with the result that neither she nor he realized that each was withholding information about the child's death from the other.

November 4: MCFD District Supervisor asks for case consultation, involvement of HARC and full disclosure

By the end of October the MCFD District Supervisor and the Usma Supervisor were very frustrated. They wanted more information about the circumstances of the child's death and they wanted to work together. Each was disturbed about withholding information from the other and neither knew that the other was doing the same thing.

On November 4 the MCFD District Supervisor sent the following pressing email to his immediate superior, the Community Services Manager for the area:

> Re: NTC Child Death Sept 4/02....**PRIORITY PLEASE>>>>>>**
> There are many players and influences in this case.
>
> Issues of concern are focused on:
> 1) The legal status of the surviving child currently under sec 8....where should he be placed?
> 2) Protection investigation results of the Kith/Kin home.....

> The problem is a "catch 22"....If NTC [Usma] remove the surviving child how come we didn't remove the natural children of the resource family?
>
> The [Usma Supervisor], and myself would like to have a major consultation on this case. Immediate resource people could include HARC Resource people/Vancouver Child Abuse Team & a Representative from the Vancouver Coroner's Office. Since there is no "official" information we need someone to authorize as full a disclosure as possible to enable an "informed decision" to be made.
>
> [Usma Supervisor] and I need to be sure we are getting support for our decision from "above" and [Usma Supervisor] is clear that this is not happening for her.

Around this time MCFD provincial and regional management were also debating the terms of reference for the Director's case review relating to the death of the child. Emails about amending the initial terms of reference were passing between Aboriginal Services and MCFD regional management. The MCFD District Supervisor's November 4 email to the Community Services Manager was not copied to Aboriginal Services. Nonetheless the information sharing issue it raised was communicated to the Deputy Director, Aboriginal Services and practice analyst, by the Regional Assistant Director in a November 5 email that was otherwise about the terms of reference for the Director's case review. The relevant part of the Regional Assistant Director's email read as follows:

> Also, as a heads up (you may already know this)...In speaking with [the Community Services Manager] he advised me [the Regional Assistant Director] that the issue re the Coroner's "secrecy" and the decision not to share info appears to be causing problems in the Usma office. [The Usma Supervisor] has expressed concern that this info was kept from her by your shop and has challenged [The MCFD District Supervisor] as to why MCFD kept info (from the Coroner) from her as well. [The Community Services Manager's] sense is that [the Usma Supervisor's] level of "trust" in the process has been negatively impacted.

November 6–8: Usma applies for and gets court order granting interim custody of brother to female caregiver

Usma decided not to pursue renewal of the kith and kith agreement because the circumstances of the brother's parents had not improved. The Usma Protection Workers were unsure whether the parents were stable enough to continue to work with a kith and kin agreement, which was a voluntary arrangement.

On November 6 Usma therefore removed the child's brother from his parents' custody. He remained with the caregivers while Usma applied for an order granting interim custody to the female caregiver under section 35(2)(d) of the CFCSA.

On November 8 the court ordered the brother to be placed in the female caregiver's interim custody, subject to the supervision of the Director under the CFCSA. The materials Usma filed in court represented the following:

> In August 2002 the Director entered into a CFCSA Section 8 Kith and Kin family agreement with the family. The children were placed with aunt and uncle, [the caregivers] in Port Alberni. The family was all in agreement with this plan. The initial contract was for a period of three months during which time it was expected that the parents would continue involvement with the Director and access services to address protection concerns.

> In September 2002 one of the children, [the child], passed away. Despite this tragic accident the family still wished for the other child to remain in the home of his aunt and uncle under the agreement. At the present time the Section 8 agreement is about to expire and the Director is not prepared to renew it, as it is not proving to address the protection concerns adequately with the parents (services have not yet been accessed, contact has been extremely limited and issues of substance misuse and domestic violence have still not been addressed). In response to this the Director moved [the brother] and placed him with the same aunt and uncle as a restricted foster home, however under removed child status not under the Kith and Kin agreement.

The court plan of care filed by Usma said that:

> [The brother's] younger sibling recently passed away. Counselling and play therapy will be provided as appropriate to address any issues that may exist as a result of the incident.

It also said that play therapy and counseling would be provided to the brother for the purpose of behavioural and emotional assessment and to address his "aggressive" behaviours.

The material filed by Usma made no mention of the circumstances of the child's death or the details of her pre-placement injuries, and they conveyed no sense that the death was suspicious or still under study or investigation.

The Usma Supervisor described how she and her colleagues concluded that they could not use the information that the Coroner had given her on October 31:

> ...we were to report what we factually knew. And at that point we still were told that she had died from a fall down the stairs, autopsy results were waiting. So that's – I mean, it was called – at that point it was called an accident to us, so that's what we called it, was an accident. There was not any police – there was not like an active criminal investigation going on. We were still awaiting the outcome of these autopsy results.
>
> So we proceeded with that. And it wasn't – there was no intention to not provide the court with information or anything like that. Certainly her death – not that the results of her death were known but certainly her death was public knowledge in Port Alberni, it was in the media. And we were not able to provide more information other than what we actually factually had, and that's what we proceeded with.

November 7: Pediatrician sees brother

On November 7 the Pediatrician had seen the child's brother, in company with the female caregiver (this was the same Pediatrician who attended at the hospital on September 4 when the child died.) When the investigation contacted the Pediatrician his file did not contain the October 2 letter of referral from the Family Physician, but did contain the skeletal survey enclosed with that letter. Nonetheless, it seems fairly certain from all the circumstances, including the Pediatrician's two-and-a-half page assessment to the Family Physician, dated November 8, that the letter of referral, or at least the information in it, was communicated to the Pediatrician. His November 8 assessment started as follows:

> I had the pleasure of seeing [the brother] accompanied by his grandmother [first name of the female caregiver] for review on November 7th. [The brother] will be 4 in January and as you know it was his younger sister that died after a fairly innocuous fall down some

> stairs. The autopsy did indeed show a number of fractures at various healing stages, pathognomonic for abuse.

"Pathognomonic" is a medical term that means "distinctly characteristic of a particular disease." The Pediatrician, from his assessment letter, was apparently aware that the autopsy of the child had revealed healing rib fractures that he regarded as distinctly characteristic of abuse.

The Pediatrician's assessment went on to describe the brother's developmental delays as having improved dramatically since being with the female caregiver at the end of August; that his speech had blossomed, he played with other children in the family quite appropriately, he was happier and so on. The assessment noted that "later this week [the female caregiver's] family will be signing for interim custody of [the brother]," and concluded that "[it] appears that [the brother] currently is being supported in all ways."

On November 7 or 8, the MCFD Protection Worker assigned to the investigation recorded the following entry on Intake 12 of a telephone conversation he had with the Pediatrician around this time:

> [The Pediatrician] is involved with only [the brother] and was did [sic] see [the child] prior to the incident[14] and was in emergency when she arrived that day. [The Pediatrician] says that the injuries [the child] had were indicative of abuse and that it is his understanding that the children were subject to phy. violence in the mothers care…Medical reflects healed injury to the 2nd left intercarpal/finger. The injury according to [the Pediatrician] was from before the children came to [the female caregiver's]. [The Pediatrician] feels that [the brother] is doing great and has done a complete turn around since being at [the female caregiver's]. [The Pediatrician] feels this is a direct tribute to [the male caregiver's and the female caregiver's] quality of care.

The MCFD Protection Worker was sure he spoke to the Pediatrician about the child's death being suspicious with no cause yet determined. Not surprisingly, the Pediatrician's words about the brother doing "great" since being with the female caregiver had a reassuring effect on the MCFD Protection Worker with respect to the safety of the children in the caregivers' home.

It was difficult to reconcile the Pediatrician's very positive and reassuring November 8 assessment of the brother's placement with the caregivers, with his trained skepticism about how the child could have been fatally injured by falling down a few steps and his knowledge that she had healing rib fractures that he regarded as distinctly characteristic of abuse. The investigation then discovered that the Pediatrician did not know that the "grandmother" he met on November 7 was the female caregiver in the home where the child died on September 4. On November 7, and in conversations the Pediatrician had with social workers, he was not aware that the brother was living with the caregivers. He believed the brother was living in a different home and made no connection between the "grandmother" he met on November 7, and who he referred to in his assessment by the first name of the female caregiver, and the caregivers of the child at the time of her death.

The Pediatrician had no hesitation in telling the investigation that, even with the limited information he had on November 8 about the cause of the child's death, his perspective

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[14] The investigation learned from the Pediatrician that this was not accurate as, apart from September 4, he had not seen any children or family in this case before he saw the brother on November 7.

on the brother would have been vastly different had he been aware that the brother was in the care of those who had been responsible for his sister.

This mix-up resulted in the Pediatrician and the MCFD Protection Worker speaking at cross-purposes and both being reassured about the well-being of the brother when, with accurate information, they would have been alarmed.

Furthermore, had the Pediatrician known of the injuries in the interim autopsy report (beyond the healing rib fractures), he would have immediately known that her death was not consistent with the account of her having fallen down a few steps and that her severe injuries before death (not just the healing rib injuries) were "pathognomonic for abuse."

November 8: MCFD Protection Worker speaks with male caregiver's probation officer

On November 8 the MCFD Protection Worker assigned to the case spoke with the male caregiver's probation officer and recorded the following entry on Intake 12.

> ...The Dec/01 domestic violence took place..starting with arguing at home to physical assault in their car while going to pick up drugs. Prior D/V with no charges/Nov/01 was described by [the female caregiver] to the PO. [Male caregiver] re-enrolled in "Lifeline" treatment Nov/02 as he did not complete prior program due to this incident plus the suicide of sister in Aug/02 in Gold River. [Male caregiver] going to [counsellor] for traumatic stress counseling....[male caregiver] has extensive assault history from 15 yrs. States he is now aware of the effect of his drug/violence toward his children.

November 8: District MCFD completes investigation of Intake 12 and makes decision that children not in need of protection

Right from September, the MCFD district office had the prospect that autopsy results would be coming soon. The impending arrival of an autopsy report then became a moving target for the investigation of Intake 12, a waiting pattern that ultimately consumed months and was a distraction away from the information that MCFD did have.

These problems were compounded by an expectation that the female caregiver would vigorously challenge the removal of her children. The view of the MCFD district office was that the female caregiver might well succeed because verbal reports from the police or Coroner about the inconsistency of the child's injuries with a fall down a few steps might not meet, to the satisfaction of a court, the "likelihood of physical harm" standard for child protection action. As the MCFD Protection Worker put it:

> **A.** ...We had that sense in Port Alberni that you don't just throw something willy-nilly in front of a judge, because the consequences could be great, which is you as the social worker tainting the Ministry.
>
> **Q.** You have to have a conviction of your own decision before you expect the court to look at it.
>
> **A.** Exactly. I'm not sure if that was part of the reasoning behind why we didn't go that route with [Intake] 12. I think there is a lot more stuff around, like I keep saying, what we didn't have. And our concern is – to be honest in a court report is you don't just put all the bad; you have to be honest and give a balanced approach. These are the

reasons why we're removing. To sit down and say that the probation officer has nothing but good things to say, the school has nothing but good things to say, and the family doctor says, "I haven't seen any signs of physical violence, otherwise I would have told you." So, no, there isn't anything. The pediatrician at the time has nothing but praise for [the caregivers], who we thought were on very slippery ground on if we went to court. We're focusing on something is inconsistent here, something is not right, and in the meantime we would like, you know, the children to be with the family. In that context it makes pure sense, and you have go. Why didn't we do that? I think when we step back and we look at the larger picture, which I know in conversations with [the MCFD District Supervisor], I think we felt we were on really slippery ground to go that route.

Intake 12 was finally concluded on November 8. The finding was "No evidence of physical harm or likelihood" and, because Risk Decision 4 (child needs protection?) was answered "No," a comprehensive risk assessment was not done on the caregivers' home.

Intake 12 ended with the following summary:

> Intake opened due to death of a child…in the home. Cause of death is currently not known. MCFD investigated the safety of the remaining children in the home based on the situation. All the children were interviewed as to remove any doubt of a "likelihood" that these other children are at risk. The two oldest children [the caregivers' two daughters] express a strong sense of safety ay home. Neither child discloses any concerns around violence at home and both describe a positive home life.
>
> Family doctor indicated /Nov 08/02..office would have contacted if they had a concern…the skeletal on [the brother] reflected no concerns/just healed broken finger…School expressed no protection concerns regarding [the caregivers' daughters]. Decision not to proceed currently with further medical examinations with [the female caregiver's] children based upon children sense of safety.
>
> Should Coroner's report reflect protection concerns re: [the female caregiver's] home MCFD will proceed at this point.

Intake 12 never sat well for the MCFD Protection Worker and it remained in his mind despite the sign-off on November 8:

> **A.** …Intake 12 was – it was very frustrating. It was very start, stop, start, stop and it was very confusing.
>
> …
>
> …It was one where we would start, we would engage with the police, and it was always – everything was always just out of distance. That's the best way of putting it, everything was just out of grasp. "The coroner's report is coming." You would have to call the police several times. They would be busy. You play phone tag. They would call and I would be busy. Interviews with anybody was just – it was just odd. I don't know how else to describe it. It just was really odd. Everything was just – there was a context that something wasn't right, something wasn't right in that home.
>
> You had a child who passed away, and then all of a sudden people are talking about how it's inconsistent. Then you've got this story about how this little boy pushed this little girl down the stairs. And I remember talking with [the caregivers] about that. And you had this sadness and a reflection on, you know, how he's found his culture and

everything is better now. Conversations with doctors, conversations with collaterals, which would be the school, and everyone just – everyone saying everything was fine.

So it didn't fit. It was like trying to jam a piece of puzzle in a spot where it didn't work. Nothing was right. You had this – potentially something very horrific happened, but everyone is telling you everything was roses. Everyone is telling you how these kids flourished since being in [the caregivers'] home, the schools just praising the family. I remember [the Pediatrician] –

...

- yes, just raving about them and hinting that if – he actually, I remember, stated that when he fist saw [the deceased child], he talked about how he had concerns. But he then linked it to [the mother]. And so it was just this really leaping away from [the caregivers].

...

Q. ...do you know what kind of information [the Pediatrician] was given, perhaps, by Usma or anybody else so that in terms of looking at [the brother], what's he got to work with other than talking to the little boy?

A. I don't know, I don't know what he was told.

For the MCFD District Supervisor Intake 12 was only administratively concluded pending the arrival of more information about the child's death:

So what happened at the end of November, I think a few weeks later I went on holidays after this. The file had been closed. It was obviously – the file was closed from an administrative point of view....but we were keeping it on our desks. It is not a closed file. Obviously if I am writing emails the file is not closed from a realistic point of view. We were waiting for the Coroner's information. I knew [the Usma Supervisor] was trying to seek it out. It was a priority for [the Usma Supervisor] to seek out the information. So the file was waiting there to get that, if that's what it took. We let everybody know. We had let my manager know. I had let the quality manager know; [the Regional Assistant Director]. They all knew we were looking for that piece of information because they knew what we had and I went away from late December and then it started again in January.

Neither Usma nor MCFD do a comprehensive risk assessment at this time

Throughout this period of the investigation and decision-making about the appropriateness of the caregivers' home as a placement, no comprehensive risk assessment under MCFD's Risk Assessment Model was done of the brother or the caregivers' children. Such an assessment would have involved a more in-depth look at the evidence and analysis of the risks inherent in the situation. The focus of the protection workers on the child's healing rib fractures and the deduction that these injuries likely happened before she was placed with the caregivers, or possibly through parental access to the child in the caregivers' home, had the effect of turning their spotlight on the parents and away from the issue of whether the children were at risk of harm with the caregivers.

Background: Comprehensive risk assessment and the rule of the third report

Risk decision #5 is "assessing the risk of future abuse or neglect of a child."

A risk assessment entails reviewing the major child, family and social factors associated with child abuse or neglect and establishing the degree to which these factors are present in a particular protection case. It provides the information base for determining what services and interventions to include in the risk reduction service plan.

A protection worker will assess risk periodically and at critical points throughout the time a protection case remains open. In certain circumstances a comprehensive risk assessment is done. This involves the time-consuming rating of twenty-three risk factors followed by a risk analysis.

Under the MCFD Risk Assessment Model the first comprehensive risk assessment is required to be done after an investigation finds, at Risk Decision 4, that a child is in need of protection. Also, a comprehensive risk assessment is required when a young child is the subject of three child protection reports in one year. This is called the "rule of third report" (MCFD Practice Standard 24 and AOPSI Practice Standard 22). As the commentary to the MCFD Practice Standards for Child Protection handbook explains:

> In the case of a third report about a young child within one year, a comprehensive risk assessment is always done. Research shows that a third report indicates high risk even if the child is not currently in need of protection.

If the circumstances warrant it, a comprehensive risk assessment may be done at any time in a protection investigation.

In the case of the brother, there had been more than three protection reports in the year preceding the child's death. Usma had done a comprehensive risk assessment on the child and her brother after deciding that the children were in need of protection in relation to their parents and prior to the placement of the children in the caregivers' home under a kith and kin agreement. The additional report that triggered the district MCFD Intake 12 investigation could have resulted in the application of the rule of third report and the undertaking of a comprehensive risk assessment even though the other reports had been in relation to concerns about the brother's parents. While the protection concerns at this point had shifted from the parents to the caregivers and the parents, the report and the risk assessment are of the child. The brother, because he had been the subject of so many protection concerns, could be expected to be very vulnerable when he was placed in the caregivers' home. The death of his sister, whether he was the final cause or not, only increased his vulnerability, and a comprehensive assessment of his risk in that home would have been in order.

With respect to the other children, the district MCFD did an investigation into the question of whether they were in need of protection. The Risk Decision 4, however, was that the children were not in need of protection, and therefore no comprehensive risk assessment was triggered. The district MCFD did do a comprehensive risk assessment in relation to the caregivers' children in March 2003.

While a decision that a child is in need of protection or a third report within one year

trigger a comprehensive risk assessment, one could be done at any time. The death of the child on September 4, in combination with all the contemporary and historical circumstances of all of the children and the caregivers and the fact that uncertainty shrouded the medical information about the death should have been more than enough to trigger a comprehensive risk assessment even without a finding that the children were in need of protection.

2.5 November 9, 2002–January 15, 2003: Waiting for the Final Autopsy Report

By November 9, 2002, Usma had made the decision to leave the brother in the caregivers' home and the district MCFD had closed off its investigation. Yet there remained a cloud of uncertainty around the information in the interim autopsy report. Everyone was waiting for the final report.

Throughout the fall of 2002 and early 2003, the Coroner received regular inquiries about autopsy results from family, police, protection workers and at least one doctor. He consistently pursued those inquiries and made many of his own with the pathologist. He also responded promptly to requests from the pathologist for information about microscopy results and the child's medical or family history. The final autopsy report was completed on January 16, 2003.

Late November: Usma does file review and receives psychologist's assessment of brother

At the end of November one of the Usma Protection Workers assembled a family service file review relating to the child, her brother and their parents from August 9 to November 9, 2002. The Usma Supervisor signed off the review. The protection workers' focus on risk to the brother through parental access, rather than from either of the caregivers, continued to be very evident:

> [The child and her brother] appear to be thriving in the home of [the female caregiver]. They are both more open to affection, developmental delays have been assessed and [the brother] is now attending daycares to assist in social skills and language skills.
>
> On September 4, a tragic accident leads to the death of [the child] (see Intake 4820). Her brother…pushed her down the stairs. She was pronounced dead when she arrived at the hospital. Cause of death is under investigation by the Coroner's office. [The brother] has remained at [the female caregiver's] home. There was evidence of healed fractures on [the child's] body. A full body x-ray taken of [the brother] in September. [The Family Physician] reports that there was one healed fracture on [the brother's] second metacarpal base of middle finger. He did not feel it was necessary for further follow-up, this type of break can be found on many children. No other signs of abuse.
>
> [The brother] continues to do well in the home of [the female caregiver]. A referral was made for [the brother] to see [the Pediatrician]…and to see a play therapist.
>
> …
>
> At this time, [the brother] is in the interim custody of [the female caregiver], no risk to [the brother]. Parents have not accessed services. Risk to [the brother] is high if left unsupervised. All visits will be supervised.

The mindset that the child's death was most likely attributable to pre-placement maltreatment followed by a tragic push by her brother down some stairs was reflected in Usma's continuing concern for the healthy development of the brother and its referral of him to a psychologist for assessment. The child's fall was regarded as a fact and the inconsistency of her severe post-placement injuries with a simple fall down a few steps

was not understood at all. A November 14 letter from Usma to a psychologist said that the brother had been referred to a Pediatrician around his developmental delays and it provided the following background about his life with his parents and the death of his sister:

> The risk assessment summary speaks to how our program became involved with this family. Family members concerns have been mainly around this couple's violence, the children witnessing this violence and neglect arising from substance misuse. [The mother] is known to be abusive to [the child's brother]. ...She has also been seen pushing [the brother], to the point he falls down.
>
> [The brother] has lived with his great aunt since August 21, 2002. His deceased sister...also lived with them. On September 4, [the child] died. It is believed she died from a fall; [the brother] pushed her down the stairs. A Coroner's inquest is still pending, to determine the cause of death. There is some concern that [the child's] body displayed some signs of historical abuse-healed fractures. A skeletal x-ray on [the brother] revealed one healed fracture of his finger.
>
> Since [the brother] has been in his aunt's home, he has done very well...

Not surprisingly, the psychologist conducted her work on much the same understanding of the child's death and the brother pre- and post-placement environments as the Usma Protection Workers. The psychologist's December 1 assessment said:

> [The brother] was referred for assessment because of concerns related to the impact of his early environment on his development and on his ability to respond in an emotionally healthy manner to future situations. His aggressive behaviour toward his sister at the end of the summer (pushing her down the stairs) resulted in injuries that contributed to her death in early September. There has, therefore, been concerns for safety of the other children in the home.

The assessment also suggested the brother's placement with the caregivers "has been a beneficial one" and that "[c]ontinued living with the [female caregiver and the male caregiver] should definitely be supported."

November 26–27: MCFD District Supervisor follows up on his request for major consultation including HARC and Chief Coroner's office

MCFD District Supervisor's request and Regional Assistant Director's response

On November 26 the MCFD District Supervisor followed up on his November 4 email asking for a major consultation that included HARC and the Chief Coroner's office, by forwarding that email again to the Community Services Manager and this time to the Regional Assistant Director as well, with the following added note:

> [The Usma Supervisor] and I sent this note out, independently, to our managers.
>
> Our request has not received any attention or significant reply to date.
> Will we receive any feedback from this request?
>
> We are prepared to share this frustration at our Director's Review.

The Regional Assistant Director responded to the MCFD District Supervisor the next day. His November 27 message was also addressed to the Community Services Manager and the south island Child Protection Consultant:

> Hi…as much as I'd LIKE to wade into this discussion I feel that, given my AD-Review role, my hands are somewhat tied. My "opinion" is that [the MCFD Community Services Manager] should lead this discussion and include [the Child Protection Consultant] to address the clinical issues. I would prefer that the issues [the MCFD District Supervisor and the Usma Supervisor] have raised (and they are good issues) be addressed well before the DirReview process is completed. It would be unfortunate if the "frustration" is only dealt with through the DR process…of course, then I will be involved.
>
> I will copy [the Child Protection Consultant] as a heads up – should [the MCFD Community Services Manager] wish to include/consult with her.
>
> Also, if anyone feels that I should play an immediate role…please let me know.

These emails were not sent to Aboriginal Services even though Usma's delegated authority under the CFCSA in relation to the brother flowed through the Deputy Director, Aboriginal Services, not the MCFD district or regional offices. The Deputy Director, Aboriginal Services told us that she had no recollection of being aware of the MCFD District Supervisor's requests in these emails and the investigation found no records that indicated she was. Not only was there no management action on the MCFD District Supervisor's requests for case consultation and HARC involvement, but Aboriginal Services was not told about the requests or the important issues raised in them.

There were two organizational reasons behind the Regional Assistant Director's response to the District Supervisor's request for his involvement in bringing about a major consultation.

Firstly, before the regional devolution of director responsibilities under the CFCSA in July 2002 there had been a direct reporting relationship between the MCFD District Supervisor and the Regional Assistant Director in his position at the time as Child Protection Manager. Since then the MCFD District Supervisor's direct reporting relationship was to the Community Services Manager for his area, not to the Regional Assistant Director.

Secondly, the Regional Assistant Director was of the view that it would be improper for him, as representative of the Deputy Director, to become too involved in decision-making. His view was based on his understanding of findings in another case, which he believed said that:

> **A.** …the director's office needs to be distant, separate, and apart from the decision-making string in order to allow them to objectively review the case, given that that's part of their responsibility should they need to.
>
> So when the director responsibilities were devolved to the regions, so when…became the regional director, and in the other four regions there was a regional director, and we became assistant directors and the child protection manager's position went away, one of the bits that we were instructed on by headquarters people who were leading the devolution process was to be careful not to blur the lines between providing direction on a case and your review, because if you provide direction, it compromises your capacity to review.

So that is what I was trying to articulate in a not very articulate way in my November 27. So my upper case of the ""LIKE" is I actually like getting involved in the case discussion. So it was in that context I was putting it.

Q. The Director's case review was into [the child's] death and also the events leading up to it, right?

A. Right, but it wasn't specific to the Director's case review. It's general to the review process et al.

Q. Even one that didn't exist yet?

A. Correct. So if you are a social worker and you phone me as the director about the "Smith" case and ask me for direction, I'm not going to, unless it's sort of life and death at the immediate moment, provide you with the direction. If I'm going to provide you with any sort of consultative opinion, I'm going to be crystal clear that that's what it is and it shouldn't be reflected in your notes as "...the director, said we needed to do X," because two years from now, when the public guardian, public trustee, the ombudsman, or whoever decides to review something either internal or external to the Ministry, then that compromises the director's role.

So we have all, we – I think I can speak in fairness for the other directors in the other regions – we have all learned since the devolution, which happened in 2001. We have learned how to manage this in a way that allows us now to engage in case consultation and conversations. But as I sort of referenced, we add the proviso that the running record can't say or shouldn't say, "....., the director, said to do X," because that puts me in an awkward spot should the decision need to be reviewed. And given that I have that responsibility within a region, it's problematic.

Q. I guess [the MCFD District Manager's] email of November 26, the one you're responding to, strikes me as a cry for help.

A. Yes.

Q. And also that he would be prepared to put in his email that he was prepared to share his frustration with the Director's review, which almost has an ominous tone to it.

A. Yes.

Q. Again, it does strike one as a cry for help.

A. Right.

Q. Did you expect that help or at least that his request was going to be responded to?

A. Absolutely.

Q. By the channels and powers that were supposed to?

A. Yes, absolutely. In the note, in the second to last line and the last line, I identify the consultant who could be of assistance should [the Community Services Manager] wish to consult with her. And I also added the proviso, if there is an immediate role, like immediate health and safety for a child, please let me know.

Q. Did anybody get back to you on that?

A. Not that I recall....

The MCFD District Supervisor was exasperated by the non-responsiveness of MCFD management and the Regional Assistant Director's view that it was not appropriate for him to get involved:

> **Q.** Can I ask you about this rationale here that as much as he would like to wade into the discussion – this is [the Regional Assistant Director] talking in his email – "I feel given his Assistant Director – review role, my hands are somewhat tied," what did you take that to mean?
>
> **A.** I don't consider anybody's hands should be tied and I consider that gobbledygook. I feel, just a minute here. We have got [the Deputy Director, Aboriginal Services, the Executive Director, Aboriginal Services] – we have a lot of key players, by November 27th, who have been discussing this case down in wherever they are, right, and I am rattling trees, and I am trying to get information and I am being told by certain parties or parameters that I am not wishing to be – I don't want to wade into this or I don't feel it's my role, and we work as a team and this is an indicator from my opinion that we are not really working as a team.
>
> **Q.** Did you understand there to be a policy within the Ministry, or at the very least a practice I think was said to arise from the…case review that somehow a person who is either in an Assistant Deputy or Director role might have to be detached from actual case decisions in order not to be tainted or be too involved or to become involved at all with decisions they might have to review in the future?
>
> **A.** I think, yes, I would be aware of that, but from a field – that is a decision.
>
> **Q.** I am not trying to say that is a good practice, but –
>
> **A.** If that person, who is in charge of that role, may think they may well have to look at that later, would you not want to have full assurance that that case is being properly disclosed and is an informed….What I am really thinking is look, the people in the upper echelons of the Director's office are well aware that we are having to make decisions. We are feeling that we are not getting the full amount of information and the last thing a field officer wants to hear is, I am going to refer it back down. What I want to hear is, I am setting this up and I will make sure this is handled and we are going to get all the resources to you, and these are the key people to lead this. That's what is being asked.
>
> …
>
> …the information I had to this date was there was people in the coroner's office that knew more than I did. I am not really aware of – at that point I didn't know people in Aboriginal Services were more aware of the information that I had, but the last direction I want to do is go backwards. I tried to – and [the Usma Supervisor] has tried to get information. We don't have the information, so I am kind of going to the – up here, which could be [the Community Services Manager]. Is he prepared to shake the tree? I am looking for someone to shake the tree.

There was no record of further contact with the Assistant Regional Director by anyone asking him to "play an immediate role" until January 2003, when the MCFD District Supervisor resumed asking MCFD management for a case consultation and HARC services.

Community Services Manager's perspective

The Community Services Manager's recollection was that he supported the District

Supervisor's desire for a major consultation. He believed that at a managers' meeting in Victoria he discussed the case with the south island Child Protection Consultant, but could not recall the outcome. The Community Services Manager also remembered, in reference to the September 20 conference call of MCFD managers, that there was confusion or disagreement about the roles of the Provincial Director, Regional Director, Assistant Regional Director and Executive Director, Aboriginal Services:

A. …Now, to me there seemed to be some mix-up in who was doing the child protection stuff, like whether it was – whether [the Regional Director] as the Director, or [the Executive Director, Aboriginal Services] as the director for Aboriginal Services – or [the Provincial Director] I guess was the Director of Aboriginal Services, but between the two of them, whose responsibility is it to do what? Maybe it was just in my mind but I found that to be a bit of a mix-up.

Q. And it's sort of referred to in that [September 18] email there isn't it?

A. Yes. And also in the role of [the Assistant Regional Director] in all this as the Assistant Director, because he was also the Child Protection Manager before that. Whether they combined the two at that time, a lot of times [the Assistant Regional Director] referred a lot of this stuff back to me, with the ongoing day to day stuff, which I dealt with [the MCFD District Supervisor], but I still felt that as, quote, 'Director or Protection Manager', that this was a case that was more for him to deal with than me.

Q. Do you recall whether he agreed or disagreed?

A. Oh, he disagreed.

Q. Or was alive to that debate? Okay. Let's hear about that?

A. He was sort of on the point of view he was going to have to do the follow-up investigation if things went wrong, so therefore, it was up to me to do the original investigation, or to be involved in it, and I said, well, that is fine, by you know, from titles, I just felt that was more his concern than mine, but –

Q. Did you have discussion with him about that?

A. Oh, yeah.

Q. More than once?

A. Oh, yeah.

Q. On other files too?

A. No. I can't recall other files. There were times though he would refer things back to me that, you know, [the MCFD District Supervisor] or somebody would go to him with, which was fine. I mean, I didn't have a problem with that but in this case I just – I kind of was confused as to whose role was what when it came to who is going to make the decision on what is going to happen, whether it was going to be the Aboriginal Services Manager, or Aboriginal Director or the Director of Child Protection.

Q. Or both, because there are kids in both arenas in the home, right?

A. Exactly. So now what went on between them, I might not have been privy to. I don't know.

Q. Do you know if any of the – I don't want to necessarily call it confusion, but any of the potential confusion about who does what, including [the Regional Assistant

Director's] view of maybe some limitations on what his role was, do you think it affected people's effectiveness or what they were going about?

A. Oh, I think it could, yes. I don't know if it did in this case, but I know it affected me in the sense of not knowing who was responsible for what. I guess it was cloudy. The whole decision making process was cloudy.

No action on consultation until March

The MCFD District Supervisor's recollection was that regional MCFD management did nothing in response to his request nor did he hear from the south island child protection consultant.

The south island Child Protection Consultant had no recollection of the November 27 email or of being consulted by anyone or otherwise involved with the case.

Specialized external resources were not engaged on the case until the latter part of March, when the MCFD District Supervisor essentially forced contact with a child protection consultant and HARC.

December 6: Coroner talks to pathologist and does not pass confirming information on to protection workers

On December 6 the Coroner called the pathologist for an update. When the call was returned later in the day the Coroner recorded the following in his case file:

- he and his colleagues have been confiring [sic] on case
- they all feel injuries due to child abuse
- nothing points at immediate cause of death
- significant abdominal injuries not condusive [sic] to described fall/push down 5 stairs
    - liver damage
    - bleeding into abdomen
    - ribs fractured
    - bruising of scalp & brain
- extent & severity of injuries do not fit
- acute injuries
- healing injuries (ribs & abdomen)
    - cold at hospital – quick cool from report of incident to hospital (ie rectal temp 35 @ 17:51)
- Microscopic examination show "nurons" [sic] in brain deprived of 0
- death not accidental or natural
- mechanism of death – not sure could be:
    - pillow over face!
    - sitting on chest or abdomen!
- too many injuries to say accidental
- appears to have repeated injuries
- age of rib fractures educated guess
    1-2 weeks
    2-3 weeks or longer
- age of abdominal injuries educated guess
    1-2 weeks
        - hopes to have report complete before Christmas

...

- 'injuries not lethal' when asked if [the child] would have died anyway within a few days - with rib fractures she should have had quit [sic] a bit of pain (how was she acting prior to death)

The Coroner went on to list information the pathologist requested him to gather over the next days from various sources (including Usma).

The pathologist's information to the Coroner on December 6 was confirming of the suspiciousness of the child's death. From the Coroner's perspective, however, it did not call for further communication to the protection workers; indeed the Coroner's view was that passing on the pathologist's December 6 information would have been inappropriate. What was needed was the final autopsy report. As the Coroner told the investigation:

Q. This call that you had with [the pathologist] on December 6th, it looks to me like when I read what is in the notes there that was basically it was pretty much confirming the worst case scenario?

A. Um-hum.

Q. Maybe it wasn't clear who the adult or adults were who perpetrated these injuries, but it was clear the worst case scenario, unnatural death – untoward injuries and death were being confirmed?

A. Yes.

Q. Was it a consideration for you, it being already December 6th then about – well, he is hoping to have the autopsy report done by Christmas, did you know there was still children in the home?

A. No.

Q. Did it – did you consider whether or not, or did you consider or feel uneasy, or was it a point of contemplation that you now knew quite a bit more about the worst case scenario being closer to reality here but the social workers didn't know that?

A. That's correct.

Q. You did now know that. Did that put you in an awkward position?

A. No.

...

Q. Did you think your job was done in terms of bringing information relating to [the child's] cause of death to their attention – done as of October 31?

A. My job is never done.

Q. So on December 6th, did you think you had more of a job to do in that regard? I am not saying that critically.

A. Eventually I would have more of a job to do once the autopsy results became known, and I could emphatically, black and white, go to these people and say, I am handing it over to the police. If [the pathologist] had said this child died of head injuries as a result of a fall down the stairs, or died as a result of a broken neck as a result of falling down these stairs – still possible – then we wouldn't have to tell them that particular news or turn it over to the police.

CORONER'S COUNSEL: I would like to point out again for the record that the Coroner really can't say and pass on verbal comments from the pathologist.

Q. That's what I am trying to elicit. That is what I want to know. If that is the case I want to hear about that.

CORONER'S COUNSEL: The problem is they change their minds. Until you have that final report out that says, here it is and it's in writing with a signature on it –

Q. I guess it seems to me and it's easy to see these things in hindsight but on October 31st a lot of provisos and cautions were given to [the Usma Supervisor] about the information she was provided; this is not for sure. Maybe. Maybe not. Her notes show that?

A. We instructed her that it is preliminary only and preliminary is subject to change.

Q. I guess when I just read what happened on December 6th in this conversation, it strikes me that there was a significant amount of confirmation that the worst case scenario was being realized, and that is why I am just trying to explore whether or not at this point – I mean, presumably you would like to have the autopsy report that day, but you don't?

A. I gave her the information and she can deduct from that anything that she wants, and I think that her deduction was not much different than mine

Q. If she was to phone [the pathologist] its none of her business, right?

A. It is not proper for –

...

Q. If she phoned, that wouldn't have been right?

A. [The pathologist] wouldn't have talked to her because he is working for the Coroners Service.

January 16: Final autopsy report completed

As time had passed, the Coroner, police and social workers had all become very frustrated about how long it was taking to get final autopsy results. The final autopsy report was concluded on January 16 and faxed to the Coroner the next day. The stated cause of death was "battered child syndrome."

2.6 January 16–February 3, 2003: Final Autopsy Report and Usma's Decision to Remove the Brother

The final autopsy report was completed on January 16. Usma and the district MCFD were told that the child's death was suspicious and that the police were starting a homicide investigation. By this time the caregivers had separated and the male caregiver was no longer in the home. Usma decided to remove the brother from the female caregiver's custody; the district MCFD considered but decided not to remove the caregivers' children.

Contents of final autopsy report

The final autopsy report consisted of a one-page cover of principal findings that were signed by the pathologist on January 16; six pages of gross findings that were transcribed on September 15 and separately signed by the pathologist; a four-page addendum to the gross findings (reporting on microscopy results and summarizing the history of the case and findings on cause of death) that was transcribed on January 3 and signed by the pathologist on January 16; and a final page listing medical reference materials on child battery and fatal child abuse.

Other records indicate that the microscopy results relating to the autopsy were completed on September 20 (toxicology), September 24 (eye tissue) and November 22 (brain tissue).

The September 15 gross findings in the final autopsy report are virtually the same as they appear in the September 9 interim autopsy report.

January 20–24: Coroner provides police with copy of final autopsy report and meets with Police Officer and Usma Supervisor

On January 20 the Coroner dropped off a copy of the final autopsy report with the police in Port Alberni and on January 24, a Friday, the Coroner arranged a meeting with Usma Supervisor and two police officers at the police detachment.

Around this time, Usma (and the district MCFD) also learned, and Usma informed the police, that the caregivers had recently separated and the male caregiver was no longer living at the home.

Usma Supervisor's recollection and record of what she was told

The Usma Supervisor's recollection was she was told on January 24 that the child's injuries were suspicious and that the Coroner's investigation was being turned over to a police investigation, but she was not shown the final autopsy report or told about its conclusion, battered child syndrome. In contrast, the Coroner's recollection was that on this day he told her the cause of death was battered child syndrome.

The Usma file record read: "...the Director [*sic*] was informed by the RCMP that the death of [the brother's] sibling...had become a police investigation due to the suspicious nature of [the child's] death." The Usma court application to remove the brother from the female caregiver that was made within days of the meeting is couched in these same terms and makes no mention of "battered child syndrome."

Police record and recollection of what Usma Supervisor was told

The police file record concerning the January 24 meeting read as follows:

> She [the Usma Supervisor] had earlier been apprised of the results of the preliminary autopsy results and was asked by [the Coroner] to keep those findings confidential. She required the information as a decision had to be made as to whether or not [the brother] was to remain in the foster home. She advised that a full skeletal examination was done and that [the brother] was monitored closely as well as being placed in a day care situation to help with his development both physically and socially. He apparently is thriving as a result. Before that he could not speak and would do a lot of grunting, would become frustrated and act out physically. She advised that if necessary a follow-up physical examination of [the brother] could be done to determine if he has since received any type of injury. *She was advised that due to the autopsy results the investigation was now a police matter. She was advised that the injuries were suspicious and that those referred to in the preliminary results still stood. She was told that due to the nature of the investigation at this point in time she would not be told the exact cause of death* and that it was the preference of us to notify the family when interviews of the family members could be conducted.... [emphasis added]

The two police officers at the meeting confirmed to this investigation that, in their recollection, their recorded information about the January 24 meeting was accurate, including the specification that the Usma Supervisor was not told the exact cause of death. They also acknowledged, however, that they could not speak to conversation, if any occurred, between the Coroner and the Usma Supervisor outside of the presence of the police.

Coroner's record and recollection of what he told Usma Supervisor

The Coroner's file record for January 24 noted a call to the pathologist at 9:00 am; a call to the Usma Supervisor to set up a meeting at the police detachment at 9:05 am; a call from the pathologist at 11:41 am; and the meeting in the afternoon with police and the Usma Supervisor. There were no particulars recorded of what was discussed in the Coroner's call with the Usma Supervisor or the meeting with the police that followed. However, a chronology that was prepared by the Coroners Service in response to inquiries from MCFD headquarters in the spring of 2004 contained the following entries:

> 09:05 – 24 Jan 03 – Called [the Usma Supervisor] and requested a meeting with her this date at the RCMP detachment at 15:30 hrs. OK.
>
> 15:30 – 24 Jan 03 – Meeting at RCMP detachment. Present at meeting: [two police officers, the Usma Supervisor] and myself.
> I advised [the Usma Supervisor] that I have received the final autopsy report and that I have now turned over the autopsy report to the RCMP for further investigation. *[The Usma Supervisor] was advised in confidence the COD [cause of death] and vowed to assist the RCMP with the investigation.* [emphasis added]

The Coroner's recollection to this investigation was also that he told the Usma Supervisor the cause of death at the meeting at the police detachment on January 24:

> I said to [the Usma Supervisor] – she knew something was happening. Why else would you get called to the police station? I said, [the Usma Supervisor], the autopsy report is

> complete. We have it in our hands. This is what [the pathologist] says, battered child syndrome is the cause of death. I am now handing it over to the police as a criminal investigation. I back out. That's it.

He later also said:

> ...and I called [the Usma Supervisor] at nine o'clock. Obviously I didn't get through to [the pathologist] at nine o'clock. Shortly after that I phoned [the Usma Supervisor], asked her to meet us at the R.C.M.P. station. I received a call back from [the pathologist] and we discussed – my little scratches are on the pages there with questions of what we discussed.
>
> ...
>
> And so then at the appropriate time there, at 3:30 that day I went to the R.C.M.P. detachment and met [the two police officers and the Usma Supervisor]. We went into their boardroom.
>
> ...
>
> And I told [the Usma Supervisor] the results of the autopsy, that you know there was a battered child syndrome, and I was turning the report or the – over to the R.C.M.P. for investigation.

The Coroner's recollection, as described to the investigation, was that he told the Usma Supervisor that the cause of death was battered child syndrome in the meeting with police, not in a conversation that excluded the police. His recollection is not consistent with the recollections of the police or the Usma Supervisor, as related to the investigation or as recorded in their respective contemporaneous file records. The Coroner's own contemporaneous file record is not detailed about what was discussed with the Usma Supervisor. The Coroners Service chronology noting that the Coroner told the Usma Supervisor the cause of death in confidence on January 24 was prepared over a year after the events in question.

Reconciling conflicting recollections

All in all, despite the Coroner's different recollection, it is most likely that the Usma Supervisor did not learn on January 24 that the cause of death was "battered child syndrome." Indeed, for the Usma Supervisor to have been told on January 24, "in confidence" or otherwise, that the cause of death was battered child syndrome, would have been both contradictory to the police record that the Usma Supervisor "was told that due to the nature of the investigation at this point in time she would not be told the exact cause of death," and inconsistent with the fact that the "battered child syndrome" information was not given to the district MCFD until February 25.

If the Coroner did tell the Usma Supervisor "in confidence" on January 24 that the cause of death was battered child syndrome, it was another scenario like the one on October 31, where the Usma Supervisor knew important information that was not shared with the district MCFD or with the court (on Usma's application to remove the brother from the interim custody of the female caregiver).

In any case, from what the Usma Supervisor learned at the January 24 meeting with the Coroner and the police officers, she realized that, even though no particular person was identified as having caused the child's injuries, Usma had to make a decision about whether to remove the brother from the female caregiver. Before making that decision she wanted to consult about that with the Usma Director, her Usma Protection Worker colleagues and the MCFD District Supervisor.

January 27: District MCFD opens new Intake and requests final autopsy report

Around January 27 the MCFD Protection Worker learned from the police that on January 22 they had received information from the Coroner that "due to the suspicious nature of [the child's] cause of death...he would not be concluding his investigation until the RCMP completed their involvement." The MCFD Protection Worker also learned that the police would be conducting a homicide investigation, and he responded by opening MCFD Intake 13, which effectively reopened what had remained "unknown" about the child's death on Intake 12. He did not realize that the police were in possession of the final autopsy report.

The Aboriginal Services Practice Analyst also called the Coroner on January 27 for an update. The Coroner recorded on a one-page form for "routine requests for information" that the Aboriginal Services Practice Analyst (including his address at MCFD headquarters) had requested copies of the judgment of inquiry[15] and autopsy report. The space on the form was blank for the date that the requested information was sent. The Coroner explained to the investigation how this worked:

> **Q.** It's entered but he gets nothing?
>
> **A.** Oh, he will.
>
> **Q.** He didn't get anything then. I just want to deal with then.
>
> **A.** No. It's only sent out after the file is closed.
>
> **Q.** And not before?
>
> **A.** Not before. Nobody.
>
> **Q.** Never?
>
> **A.** Except if it's involved with somebody doing an investigation.
>
> ...
>
> **Q.** Right. You got his request. Do you remember that conversation or giving him a response when he asked for this information?
>
> **A.** Probably would have advised him at that point that the autopsy report would not be sent out until the judgment of inquiry was written or until my investigation was complete, as is the standard answer for everyone.
>
> ...
>
> **A.** If [the Aboriginal Services Practice Analyst] would have presented to me that he was doing an investigation and it was part of his investigation, that he needed it now, then I would have consulted with my regional coroner and it would have gone from there.

January 28: Police Officer meets with Usma Supervisor and MCFD District Supervisor

On January 28 the Police Officer asked to meet with the Usma Supervisor. The Usma Supervisor provided contact information for the female caregiver and the Police Officer

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[15] A judgment of inquiry is the concluding document when a Coroner's inquiry instead of a public inquest is done under the *Coroners Act*.

requested Usma file information about the deceased child and her brother.

The next day there was a meeting with police that was attended by the MCFD District Supervisor and the MCFD Protection Worker and the Usma Supervisor. The MCFD District Supervisor requested further information but the police were not prepared to release more at that stage of their homicide investigation and maintained that it was enough to say "that injuries not consistent with fall as reported." Again the MCFD Protection Worker (and this time the District Supervisor as well) did not realize that the police were in possession of the final autopsy report.

The record entered on Intake 13 of the meeting and MCFD's decision to leave the caregivers' children with the female caregiver for the time being read as follows:

> RCMP protocol meeting to discuss how the joint investigation shall proceed. It was decided that RCMP will lead and will keep in contact with MCFD every 2 weeks or on a need to know basis. RCMP will also inform MCFD should anyone become a suspect, and MCFD needs to act in the safety of the children. RCMP to lead the investigation. Homicide investigation unit from Courtenay has already spoken with [the female caregiver]. Based on her information provided, her reaction and her demeanor, while they do not rule her out as a suspect, they are also not listing her as a suspect and feel that she may be ruled out. RCMP have the same frustrations around lack of information from the Coroner's report. What is known is that there are a number of injuries that [the child] received and that they could not have been caused from a fall down stairs. What is clear is the cause of death is not due to her falling down the five stairs. Timeframes are unclear at this point. What is evident is there is evidence of broken ribs, bruising did not appear initially, but did appear afterwards, indicating it was probably a very recent injury. RCMP as well as MCFD have numerous questions around Coroner's information. RCMP will be in touch with the pathologist, as well as [the Port Alberni Pediatrician], looking for additional information. RCMP will also be speaking with numerous individuals to try and get a clear picture of what did happen that day and what was happening in the home prior to the incident. MCFD will have to conduct a protection investigation, to be certain that the children in [the female caregiver's] home, [the brother] as well as her own children, are safe and free from abuse. [The female caregiver] has recently separated from her spouse, [the male caregiver]. MCFD's position is since [the female caregiver] is not a suspect, and MCFD has never had any past concerns in regards to [the female caregiver] being abusive towards her children and because of a previous intake, (ITK #12) children's sense of safety and the fact that [the brother] has been doing remarkably well while in [the female caregiver's] care, MCFD will ask that [the male caregiver] remain out of the home during the course of the RCMP and Ministry investigation, until she can be ruled out conclusively as a suspect.

January 29–February 3: Usma decides to remove and district MCFD decides not to remove

The Usma Supervisor's recollection was that at the January 29 meeting the MCFD District Supervisor took the view that the female caregiver was not a person of concern, as the risk for the historical intakes concerning the caregivers had been the male caregiver's substance misuse and violence. The Usma Supervisor took this away to consider and, while she saw the MCFD's point of view about the female caregiver, decided that the brother should be removed. The female caregiver remained very committed to the brother, but Usma's "decision was not based on [the female caregiver's] needs, it was

based on [the brother's] needs." The Usma Supervisor explained her thinking in this way:

> **A.** ...There was no identified person of risk in that home. But there was a risk now that I wasn't comfortable leaving [the brother] in that situation.
>
> So by the 30th of January I consulted with [an Usma Protection Worker] and made the decision to remove [the brother], just based on the fact that there was now a police investigation investigating the death of his sister, which took place in that home, that we needed to just make a decision and remove [the brother] out of that home.
>
> **Q.** Was that a hard decision for you to make, was it close to the line, or was it quite clear and obvious that it was the right thing to do?
>
> **A.** I believe it was quite clear. I think it was a decision that we had looked at as an option right from when I returned back to work in September, but certainly after the October 31 information, given that there was just – there was just something there that we couldn't put our finger on. It was nothing that we could identify and state outright. But certainly now, with this police investigation around her suspicious death, we felt that that was the right decision to make.

On February 3 Usma removed the brother on the grounds that interim custody with the female caregiver was no longer adequate to protect him "due to an open police investigation to the death of [the brother's] sibling...which the RCMP are now deeming as suspicious. The home in which [the brother] is currently living with [the female caregiver] is also now part of this investigation."

MCFD's decision to leave the caregivers' children with the female caregiver was viewed as a status quo decision that was supported by the Intake 12 investigation and conclusion that the caregivers' home was safe for children. The decision was also seen as being supported by the female caregiver's history with MCFD and by the fact that, while the female caregiver was not ruled out of being implicated in the death of child, she was not the first or obvious suspect. The MCFD District Supervisor explained his perspective that different rationales applied to the Usma and MCFD decisions:

> **Q.** ...explain your reaction to the fact that Nuu-chah-nulth took [the brother] out and how that factored into your decision about the well-being of the other children, if it factored in at all?
>
> **A.** Well, we were doing our investigation, so the appropriateness of leaving children with their mother being the least disruptive and a whole bunch of guiding principle factors that we have to take a look at, and the information that we actually had on that particular time, would have to do with the care of those children – of the birth children remaining with [the female caregiver] – or natural children. The home and the stability of [the caregivers], which was the placement of USMA of [the brother] in that home. ...So for them to make a change in placement based upon the set of circumstances; the trauma that took place, it was totally understandable for them to remove.
>
> ...
>
> ...So we now know that one of those caregivers, chances are something happened. We are doing a homicide investigation on the 28th of January, and I think serious enough questions if that was a caregiver type home you would certainly bail out of that decision at that stage. It is clearly not a stable environment for that child to be in.

So is it – the question then comes up and this was laid out at the very beginning in some emails. There is Section 8 issues. There is some emails I wrote out. There is the two things taking place and there should be some continuity in what we do, but at the same time our standard is a little bit different. But what we decided on the 28th, for the children to be able to remain in the custody of the mother when there is a split, our investigation in Intake 12 reflected really, no. Those kids were very comfortable with [the male caregiver], very comfortable with mother, and our investigations show when we remove domestic violence from the equation as a risk factor to take a look at – which we immediately do. We are now going straight to an investigation, not an assessment. That is a different phase – that the children, based on the balance of probability would be safe in the home of [the female caregiver], so we would not be removing from her at this stage. So pending completion of the investigation, for us to jump in now and remove the children, you know, we could have won, but it was a case decision.

For the Usma Supervisor, it was a clear-cut decision to remove the brother. For the MCFD District Supervisor, the MCFD decision about the caregivers' children could have gone either way, but with a police homicide investigation now underway, the previous concerns about the information that was known at the time of Intake 12 being insufficient to meet the "likelihood" test in the eyes of a court appeared to be no longer a riveting factor in the protection decision:

Q. ...was it a tough decision? Was it close to the line, if you can describe it that way?

A. It's a tough decision. It's a tough decision that actually when we came to removal, which we will come to, we did make, and we made it on exactly what we are talking about at this moment. Who is the one that inflicted harm upon this child? And we at some point had to say, we are not getting enough information to make it clear that it couldn't have been either...

...

...Right now pending the completion of making that ultimate decision, we made a decision based on the balance of probabilities; the involvement of family – there was a lot of family involved in this – that the children would be safe with her. And in hind sight we were correct, but that is hindsight.

Q. ...Hard to know whether not being on the suspect list when there is no suspects means – I mean, what does all that mean, right?

A. It means a judgment call, and that is what it really comes down to is if you take a look at all of the factors, and we tried to take a look at all of the factors and make a decision about removing and determining the safety of the children, we had a number of options. We could have removed or we could have done what we did, and we stuck to we made this call at this stage based upon still the information that we had on January 28th.

2.7 January 27–June 13, 2003: MCFD's Decision-Making Around Removing the Caregivers' Children

From late January to late March, the district MCFD continued to pursue expert consultation and more information about the child's death. A series of family plans were accepted whereby the caregivers' children lived with the female caregiver, then with relatives (where the female caregiver also lived) under conditions of supervised parental access. Soon after MCFD obtained the final autopsy report there was a consultation with HARC, which resulted in MCFD removing the caregivers' children on March 27. The children remained in the care of the Director until June 13, when the male caregiver had been charged in the child's death and the police had cleared the female caregiver of involvement.

January 27: MCFD District Supervisor renews request for case consultation and HARC involvement

With the news that the final autopsy report was complete and in the hands of the police, the MCFD District Supervisor picked up again on his emails to MCFD management about needing more "official" information on the case and wanting a major case consultation and HARC involvement. On January 27 he again forwarded his previous messages to the Community Services Manager for the area and the Regional Assistant Director, with a copy to the Usma Supervisor. He added the new information that the Coroners Service had turned the case over to the RCMP to review a "suspicious death" and said:

> - discussion with [the Regional Assistant Director] conclude that until any parent is excluded from the Investigation it would be required that none of the children, either natural or relative, live with anyone involved in the suspicious death. This planning can be either by agreement with the parent or by removal/Director's involvement if there is opposition.
> - NTC will be taking the same stance for the NTC CIC [the brother] involved in this case.
> - [The caregivers] are currently separated....and the file should note that [the male caregiver] was the initial "parent of concern".
>
> We hope that the RCMP will look at answering some of the questions we asked in the earlier part of this memo in terms of the extent and implications of the injuries. If there is a lack of clarity we trust that MCFD will provide the previously requested supports and interpretations.

On January 28 the MCFD District Supervisor sent an email to the Community Services Manager and the Regional Assistant Director, the Usma Supervisor and the MCFD Protection Worker assigned to the case, recording the following:

> Conversation with [the Regional Assistant Director] to inform him that the RCMP are not identifying anyone as a "Suspect" in this investigation. All parties will be interviewed and RCMP will set up a meeting with NTC/MCFD to outline their plan.
>
> - We understand that there is no history associated with abuse, solely linked to [the female caregiver]. Any protection concerns have involved [the male caregiver]. Therefore we can conclude that, unless informed otherwise, it would be acceptable and safe to let [the female caregiver's] children remain in her care. [The female caregiver] should/will be

informed that should [the male caregiver] re-enter the picture we would have to re-evaluate our position and proceed with an alternate plan including removal.

- RCMP will be agreeing to communicate with us and we will re-inforce the requirement under CFCS Sec 14 that they will contact us should information be revealed that there are protection concerns for any of the children.

February 24: Caregivers arrested and female caregiver's oldest brother's home considered as suitable placement

On the evening of February 24 the sister-in-law called the Usma Supervisor to tell her that the caregivers had been arrested on charges relating to the child's death and that the family plan for the night was for the sister-in-law and her husband to take in the caregivers' children. The next morning, the Usma Supervisor passed this information on to the MCFD Protection Worker. They had further conversations later in the day, including a discussion about the appropriateness of the caregivers' children being placed with the sister-in-law and her husband; the protection worker recorded the following entry on Intake 13:

> ...Conversation about [the sister-in-law and her husband's] home – Is it an appropriate placement? [The Usma Supervisor] indicates that [the sister-in-law] was once a resource for NTC and the resource was only closed, as [the sister-in-law] is now an employee of NTC and it was decided that employees should not be resources. [The sister-in-law's husband] is a school-based counselor who works with 1st nations children. [The Usma Supervisor] feels while this is a good home, her only concern would be [the sister-in-law and her husband] being caught in the middle of trying to support [the female caregiver] vs dealing with news that [the female caregiver] may have been responsible for [the child's] death and the position that may put [the sister-in-law and her husband] in.

The MCFD District Supervisor was away from February 24 to March 9. During at least some of that time the Community Services Manager for the area was also away. The MCFD Protection Worker continued to handle the case and sought guidance from the Regional Assistant Director.[16]

The MCFD Protection Worker also had further calls with the Usma Supervisor, recording the following entry on Intake 13:

> ...Indicated to [the Usma Supervisor] that I felt a removal would be in order and that I was considering a placement with [the sister-in-law]. However, my concerns were her concerns that it may be a tough position for [the sister-in-law and her husband] and that maybe a Ministry approved resource would be a better option. [The Usma Supervisor] indicates that she spoke with [the sister-in-law] who felt that a removal was probably going to be happening....

---

[16] The Regional Assistant Director and the MCFD protection worker were also independently connected through a government mentoring program under which the Regional Assistant Director was the protection worker's mentor.

February 25: MCFD Protection Worker speaks with police

The MCFD Protection Worker followed up by speaking to the police from whom he learned for the first time that the cause of the death was "battered child syndrome." His February 25 file memo about that call read as follows:

> [The police officer] said he would read the last paragraph of the autopsy report which goes as follows:
>
> "The child's injuries were typical for battered child syndrome. Battered child syndrome is indicated by the multiple instances if injuries, both evidence of recent and healing. In this case, there were multiple injuries to the chest and abdomen, also to the head. These injuries are far more than from a fall at 3-4 steps. Death is attributed to the Battered Children Syndrome."
>
> Autopsy report also indicates that the ribs (11 broken ribs, 9 of which were in the healing process and 2 broken), were in the process of healing and had been rebroken within 1 to 3 weeks. There is also indication that there is an injury up to an hour prior to death. The Autopsy concluded that the child passed away due to Battered Child Syndrome.
>
> The injuries to the chest and abdomen was such an extent, that it caused affixation and internal bleeding, but not enough to cause death. SW asked [the police officer] about the Ministry's actions, [the police officer] indicated that any action that MCFD takes will not affect the RCMP case and that we (MCFD) need to follow our mandate and do what we need to do. He just asked if we could keep in contact prior to any removals or prior to any action. [The police officer] also conclude by saying he could not say for certain who is responsible for the injuries that both [the caregivers] are in police custody right now. According to [the police officer] both [the caregivers] are equally culpable in the statements. Both [the caregivers] are seen as suspects, indicating that it could either be one of them or both of them, but [the police officer] doesn't feel there is one innocent party here.

The MCFD Protection Worker had further calls with police, who reiterated that MCFD needed to follow its child protection mandate and that both caregivers were suspects in the child's death.

February 25: Female caregiver released from police custody and MCFD Protection Worker further considers removal

By the end of February 25, the female caregiver had been released from police custody and the MCFD Protection Worker had arranged for her and the sister-in-law to come to the MCFD district office.

On February 25 there were also calls and emails between the MCFD Protection Worker and the Regional Assistant Director. After the MCFD Protection Worker spoke to the Usma Supervisor about his view that removal of the caregivers' children was in order, he spoke with the Regional Assistant Director and recorded this entry on Intake 13:

> ...I outlined the situation and indicated my feelings that a removal was needed and a finding of in need of protection, considering both parents are suspects in a suspicious death/ongoing investigation. [The Regional Assistant Director] indicated that we could go with the family plan, as the family plan is adequately protecting the children and that we would respect their plan. Should the family or parents think of changing that plan or make attempts to move the children, MCFD should remove....

The MCFD Protection Worker told the sister-in-law over the telephone that MCFD wanted to respect the family plan under which the sister-in-law wanted the female caregivers' children to remain with her. He told her the female caregiver's visits would have to be supervised and if the family deviated from the plan MCFD would remove the children. This was repeated when the female caregiver, the sister-in-law and her husband arrived at the MCFD district office. Intake 13 indicates the MCFD Protection Worker was told there was going to be a closed family meeting within the day and he indicated, and the sister-in-law and her husband agreed, that MCFD would have to be involved in any changes to the family plan.

There was then another discussion with the Regional Assistant Director during which the MCFD Protection Worker recorded on Intake 13 that he:

> ...again indicated my belief that we should be looking at a removal and a placement with [the sister-in-law]. [The Regional Assistant Director] indicated that if there are any changes or if this family plan does not look like it can protect, MCFD would remove.

Finally on February 25, the MCFD Protection Worker recorded an immediate safety assessment (Risk Decision 3 in the MCFD risk assessment model) and immediate safety plan on Intake 13. One of the fifteen "Safety Factor/Supporting Information" items was marked "Yes," two were marked "Unknown" and the rest were marked "No," and this time the answer to the overall question "Children Safe?" was "No." The two items marked "Unknown" and "Yes" read as follows, with a note added by the protection worker in upper case for each:

> 3. Parent has caused serious physical harm to the child OR has made a plausible threat that would result in physical harm to the child. (Unknown)
> CURRENTLY THERE IS A RCMP INV. DUE TO THE DEATH OF [THE CHILD] IN [THE FEMALE CAREGIVERS'] HOME. [THE CHILD'S] CAUSE OF DEATH WAS "BATTERED CHILD SYNDROME." [IT] IS CURRENTLY UNKNOWN WHO CAUSE[D] THE INJURIES TO [THE CHILD]. BOTH [FEMALE AND MALE CAREGIVER] ARE SUSPECTS.
> ...
> 5. Parent has previously harmed this OR any child, and the severity of the harm, OR the parent's prior response to the incident, suggests that the child's safety may be an immediate concern. (Yes)
> PAST IK CONCERNS AROUND DOMESTIC VIOLENCE AND POSSIBLY PHY. ABUSE IN THE FAMILY HOME.
> ...
> 8. Parent has not, OR will not, provide sufficient supervision to protect child from potentially serious harm. (Unknown)
> IT IS CURRENTLY UNCLEAR OF EITHER PARENTS ROLE IN [THE CHILD'S] DEATH.

The immediate safety plan was for MCFD to support the family plan for the caregivers' children to reside with the sister-in-law and the female caregiver's oldest brother, with only supervised access by either of the caregivers.

February 26–March 3: MCFD monitors family plan of placement with sister-in-law and female caregiver's oldest brother

On February 26 the MCFD Protection Worker and the sister-in-law again:

> ...discussed the difficult position that [the sister-in-law and her husband] are in. [The sister-in-law] indicates that they are there for the children and will focus on the children's

needs, while at the same time, try and be supportive of [the female caregiver].

Later in the day the sister-in-law asked the MCFD Protection Worker about the female caregiver's parents moving into the female caregiver's home and the children returning with her. He told her that they needed to stick with the family plan for the female caregiver's children to live with the sister-in-law and her husband.

Later still the MCFD Protection Worker consulted the Regional Assistant Director. His record of that call on Intake 13 included the following:

> Again I indicated I felt a little antsy about the situation, as the Ministry has not removed and its a family plan. [The Regional Assistant Director] indicated that if we get any feelings around concern or have any concerns arise, that this family plan is not protecting, MCFD will remove and that we should be really tight on our expectations. [The Regional Assistant Director] felt that we should probably be looking at writing [the sister-in-law and the female caregiver] a letter outlining what reside and supervise mean. Agreed with [the Regional Assistant Director]. I felt that was a good idea.

On February 27 the MCFD Protection Worker learned from the sister-in-law that a meeting of the female caregiver's family had taken place the evening before. On Intake 13 he noted: "Family supports the current placement."

On March 3 the MCFD Protection Worker had yet another discussion with the sister-in-law about how the placement of the caregivers' children was working out. He recorded the following entry on Intake 13:

> Things went well on the weekend. She feels that the family is adjusting to the situation. Again, [the MCFD Protection Worker] asked [the sister-in-law] about the position her and [her husband] are in. Indicating that it sounds she is in a very difficult position in trying to be supportive to [the female caregiver], as well as knowing MCFD's expectations. [The sister-in-law] indicates that she feels she is coping okay as well is the family.

He also spoke to the Usma Supervisor about the situation, recording the following on Intake 13:

> [The Usma Supervisor] indicates that she has spoken with [the sister-in-law]. Again, [the MCFD Protection Worker] indicated concerns about [the sister-in-law and her husband's] position. [The Usma Supervisor] indicates that [the sister-in-law] seems to be coping and most likely will mention to her and if she does, [the Usma Supervisor] will let this SW know.

On March 3 the MCFD Protection Worker met with the sister-in-law to go over the letter confirming the terms of the family plan supported by MCFD. It was addressed to the caregivers, with copies to the sister-in-law and police, and read as follows:

> This letter is to outline the current MCFD involvement with your family. Presently, MCFD is conducting a joint investigation with the local RCMP detachment concerning a report that [the caregivers children] may be in need of protection.
>
> At present, MCFD is willing to support the current family plan made on February 24, 2002, which is that the children reside with maternal extended family, [the sister-in-law and her husband]. This plan also included [another child of the maternal extended family], who at the time of the plan, was residing as Child-In-Home-Of-A-Relative with

[the female caregiver].

However, MCFD does have the following expectations regarding the family plan:

1. [The caregivers'] children are to reside at [the sister-in-law and her husband's] home until MCFD and the RCMP have concluded their investigations and/or further planning around placement options are made with MCFD

2. [The caregivers] are to have supervised visits with [their children]. Supervised access consists of a Ministry approved supervisor being present with yourselves and the children at all times, during these visits.

MCFD believes that these terms will ensure the safety of the children. Should there be any difficulties adhering to these terms, MCFD may need to plan for alternate placements to ensure the safety of the children.

Again it was agreed, and the MCFD Protection Worker noted on Intake 13, that the sister-in-law "will indicate if she needs any support if she feels things are not going well, she will let MCFD know."

During this period, the MCFD Protection Worker continued to regularly call the police. He understood the police investigation into the child's death was actively underway and that they had no further news for MCFD on the case.

March 12: District MCFD pursues consultation with HARC and receives final autopsy report from the police

The MCFD District Supervisor returned to work on March 9. After receiving an update on the case from the MCFD Protection Worker, he picked up again with trying to get the final autopsy report, a case consultation and the involvement of HARC. At the direction of the MCFD District Supervisor the MCFD Protection Worker called the police on March 10 and made the following entry on Intake 13:

> Asked if this SW could receive a copy of the autopsy report from him through a formal request or does this SW need to go straight to the pathologist. [The police officer] indicates that this SW just needs to request the report.

The MCFD Protection Worker, understanding that the final autopsy report would be forthcoming, sent a standard letter dated March 10 to the police that said MCFD was involved in completing a child protection investigation under Section 16 of the CFCSA and specifically requested a copy of the final autopsy report.

That same day the MCFD District Supervisor sent an email to the Community Services Manager, the Regional Assistant Director and the Child Protection Consultant for the area; he requested a HARC team to review and discuss the final autopsy report as soon as it was received from the police and the input of a child protection consultant. He asked if there was a protocol to follow or whether he could call HARC himself. The Regional Assistant Director replied that HARC referrals were through the child protection consultant. Further emails ensued about process and timing.

By March 12 the MCFD District Supervisor was not prepared to continue to wait any longer for a HARC referral. He pressed the urgency of the matter in an email to the Child Protection Consultant for his area (who had not been involved in his previous requests):

> I don't feel it is OK to wait any longer for the HARC involvement, so I trust you will have success in processing this request asap.
> We have been waiting for a Coroner's report since the child death in September. We had previously requested assistance in getting information and assistance from HARC a couple of months ago……no action.
>
> We now have a caregiver assessed by RCMP as a "suspect" in this child's death and have agreed to the family's alternative arrangements in order to avoid a court removal.
>
> We have a parent who has a lawyer and may change her plan to have her children returned…..and we/MCFD has still not been able to fully discuss the medical information involved in the Coroner's report.
>
> We require this information and interpretation as part of our Assessment and Investigation in regards to the home of [the female caregiver] in a timely way (as we will require such information as part of a "Report to Court" if we go that way.)
>
> Considering the seriousness of this crime and situation I feel it is appropriate to directly contact HARC and get them involved today.

The Child Protection Consultant took immediate action to arrange to meet at the MCFD district office on March 18 and to set up a meeting with HARC on March 25 in Parksville.

Also on March 12, the MCFD district office received a letter from the officer in charge at the Port Alberni police detachment, enclosing a copy of the final autopsy report. The letter noted that the report was being disclosed to MCFD under Section 8(2)(f) of the Canada *Privacy Act*, which allows federal government agencies to disclose personal information, without consent, to provincial government agencies for the purpose of administering and enforcing their provincially legislated mandates. The letter stated that the report was being released on condition that it would not be used for any other purpose (i.e., other than child protection), or given to another agency or person without written consent from the police. Some pages of the enclosed copy of the final autopsy report were marked with handwritten annotations of one of the police officers and each page was stamped with the following notice:

> This document is the property of the Government of Canada. It is loaned to your agency on the understanding that is not to be further disseminated without the consent of the originator. Distribution within your agency is to be only on a need to know basis. The document is to be protected in accordance with the normal safeguards for law enforcement information.

March 12: Family plan for caregivers' children breaks down

The MCFD District Supervisor reported in a March 11 email to the Community Services Manager, the Regional Assistant Director and the Child Protection Consultant for the area, that by family consensus the caregivers' children had been placed with extended family. However,the female caregiver's lawyer had contacted the district MCFD and it needed to be prepared to respond accordingly should the female caregiver soon request the return of her children. The MCFD Protection Worker made a more detailed entry on Intake 13 that included the following:

> [The female caregivers' lawyer] indicated that he is not happy with the RCMP investigation, in fact he feels that MCFD is being used as a pawn by the RCMP to apply pressure on [the female caregiver]. He is upset with the fact that [the female caregiver] was arrested, then

released and feels that the RCMP again are applying on her pressure through having her children elsewhere, to try and get her to co-operate with the investigation, which according to [the lawyer], she is doing fully. Indicated to [the lawyer] that MCFD's position is [the female caregiver] is a suspect and a criminal investigation causing death, which is of grave concern, and until she is removed as a suspect MCFD has to follow its mandate in looking at the safety of her children and is supportive of the family plan. [The lawyer] understands that and again indicates, according to the RCMP, [the female caregiver] has been told she is not a suspect. Indicated to [the lawyer] that this SW would speak with [the female caregiver] about this. [The lawyer] also indicated that [the female caregiver] is not happy with the current arrangement – the children being at [the sister-in-law's].

The MCFD Protection Worker spoke and met with the female caregiver, who confirmed that she was not happy with how things were going with the placement of her children in the home of her eldest brother and sister-in-law. By this time the female caregiver had moved into that home too. MCFD's requirement for only supervised parental access to the children remained in place. The female caregiver's residence in the same home as her children meant that there had to be supervision whenever she was present with any of them. Conditions were becoming tense and the female caregiver said that, after consultation with her relatives, they felt it would be best if she and her children moved down the street to the home of the daughter of her eldest brother, who also had small children.

After considering the matter, including consulting with the Usma Supervisor about the suitability of the daughter of the eldest brother (she was an Usma employee), MCFD accepted a change of the family plan for the caregivers' children. The requirement for only supervised parental access to the caregivers' children remained in place. On March 12 the MCFD Protection Worker made the following entry amending the safety plan on Intake 13:

> [The sister-in-law and her husband, the female caregiver's oldest brother] are finding the arrangement increasingly more dif. [The sister-in-law] wanting to continue with the placement and [the female caregiver's older brother] is not. [The female caregiver] is also finding the placement difficult. Family has formulated another plan. [The female caregiver] and her children are to reside with [the oldest daughter of the female caregiver's oldest brother] and her husband. [The female caregiver] and family feel this would be the arrangement. D/S consult. MCFD support of plan. P/C with [the Usma Supervisor]. [The oldest daughter of the female caregiver's oldest brother] works at NTC. Appears to be a positive place. [The oldest daughter of the female caregiver's oldest brother] is a strong support for the [female caregiver].

March 18–25: MCFD District Supervisor meets with Child Protection Consultant and with HARC

On March 18 the MCFD District Supervisor and the MCFD Protection Worker met with the Child Protection Consultant for their area. The one-page district office record of the meeting noted that the investigation of Intake 12 did not find any children in need of protection, but a new intake (Intake 13) had been recently initiated "as autopsy report made public indicates injuries that occurred prior to death inconsistent with fall downstairs." Four suggestions of the Child Protection Consultant were listed. They included a comprehensive risk assessment on both caregivers that was to be done with the Child Protection Consultant on April 8 and a

referral to HARC for review of the autopsy report.

On March 25 the MCFD District Supervisor, the MCFD Protection Worker and the Usma Supervisor met with the HARC pediatrician, two other HARC physicians and a HARC social worker. Copies of the final autopsy report were in front of everyone. This was the first time the Usma Supervisor had seen the final autopsy report. (She had to leave the report with the MCFD District Supervisor at the end of the meeting.) Much of the two-hour meeting consisted of a detailed translation by the HARC pediatrician of the final autopsy report from medical to lay language. While she did that, another physician marked a body map of what the child's injuries might have looked like. There were many concerns about how the child's death had been presented as a fall down stairs and the physicians' interpretation of the child's injuries against that account. There was a sense of urgency in the meeting. It was also an emotional one from which the MCFD and Usma participants emerged with an unequivocal understanding that the child had died of horrific, adult-inflicted injuries. In the words of one of the physicians, the "outcome of this meeting... was that – the overwhelming feeling was that somebody, somewhere, somehow should have realized that this child was battered to death earlier than what we had seen happen."

March 25–27: Decision made to remove female caregiver's children amid continuing concerns about information sharing

After meeting with HARC, the MCFD District Supervisor immediately emailed the Community Services Manager, the Regional Assistant Director and the Child Protection Consultant wanting discussion about the results of the HARC meeting and the previous plan not to remove the caregivers' children:

> [The Regional Assistant Director], you consulted with [the MCFD Protection Worker] on this case. This is the Child Battering resulting in death. We have spoken to the HARC Team to review the abuse.
> There was a decision not to remove because the mother placed her children in the care of her relatives. We are aware that she has changed homes to another caregiver and has moved in with the family (as she had done with the first family).
>
> We are aware that this battering was significant and we do not know who is the offender.
>
> We are wishing a discussion on the decision "not to remove" or even to go to court, and the results of our HARC meeting to confirm our plan.
>
> Who should be involved in this decision?

The Regional Assistant Director replied immediately: "[The Community Services Manager] and you. If you want to include me in a discussion that's fine...but [the Community Services Manager] makes the case-decision call."

On March 27 there were emails and a conference call between the MCFD District Supervisor and protection worker, Community Services Manager and Regional Assistant Director about removal of the caregivers' children and the use of the final autopsy report by MCFD to support that decision.

The MCFD District Supervisor was critical of the handling of the final autopsy report and of the handling of information about the cause of the child's death right from the start of the case:

> There are overlapping Criminal Investigation issues and we need to know how far we can go in terms of sharing the Coroner's report [the final autopsy report].
>
> We are OFFICIALLY requesting that the Director be given a true copy of the Coroner's report. The only Coroner's information that we have has been presented to us by the local RCMP. OR is it not policy for us to be informed by the Coroner? Is it assumed to be sufficient that contact with the RCMP meets Sec 14 [of the CFCSA]?
>
> I would assume that the Director would have also been given a copy of the Report so that we may be seen as operating independently from the RCMP (somewhat). The RCMP are uncomfortable with us copying/sharing much of the Coroner's Report.....but the comfort level would be reduced if we were given our own copy. (politics and perception?)
>
> We also have some concerns about the total handling of this information from the day of the tragedy. Will a more comprehensive review of the process be considered? I'm talking about the day the Director's office got a call from the Coroner but "the information cannot be shared" and thus we could not start a comprehensive Investigation.
>
> In hindsight, I feel we did not start off fast enough.

Following more emails and a conference call, the MCFD Community Services Manager wrote:

> In consultation with [the Regional Assistant Director] and with the new information from the HARC team I say we should remove these children and allow the parents to have supervised visits only until the criminal investigation is complete.

The final entry on Intake 13 suggests that the meeting with HARC brought MCFD to a point of clarity that, from the perspective of a likelihood of harm, the children should be removed. The unresolved death of a child by battery warranted the removal of all of the remaining children from any of the adults who had been responsible for the child and could be potentially implicated in her death. The entry read:

> HARC indicates it is unclear what actually caused [the child's] death, whether it was the multiple injuries to the head or the massive internal injuries. What is clear is that [the child] was severely beaten and that the force was adult in nature. Neither parent has offered an explanation as to what occurred in the home that day. [The male caregiver] will not speak with the RCMP or MCFD, he indicates to [the MCFD Protection Worker] that he has already said what occurred – [the child] was pushed by [her brother] down 4-5 stairs. [The female caregiver] says [the child] was fine that day and was healthy prior to her going to Safeway an hour before [the child] was taken to the hospital. Given the severity of the injuries to the deceased child, [the child] (she was beaten to death), the old/prior injuries, and the lack of an explanation MCFD has removed the children.
>
> Intake to be closed and file transferred to the FS team.

The caregivers' children were removed by MCFD on March 27 and placed with a relative. MCFD then had to prepare for the immediate court hearing required to justify the removal.

March 27–April 3: MCFD receives final autopsy report from regional coroner, but differing perspectives on information sharing persist

MCFD District Supervisor asks Coroner for clean copy of final autopsy report

On March 27 the MCFD District Supervisor called the Coroner, explained that he already had a copy of the final autopsy report with marks on it from the police, and requested an unmarked copy. The Coroner was alarmed by the MCFD District Supervisor's claim that he had the final autopsy report and referred him to the regional coroner. The Coroner told the investigation:

A. ...[The MCFD District Supervisor] phoned me and said, could I have a copy of the autopsy report, and I said, no, it's not public until whatever. He said, well, I have got a copy here from the RCMP and it's not legible. That is when alarm bells went off in my head because it ticked me off, that the RCMP should never have released that to him. That's not their document. I don't release their witness statements to other people and it's not their place to have given it to [the MCFD District Supervisor]. That is when I directed him to the regional coroner's office.... He then wrote the letter and got it, but he told me in that conversation that he had a copy.

Q. Yes?

A. That he had received a fax from the RCMP.

Q. Right. And you were – well, you were not too happy about that I guess. Did you have words with the RCMP about that?

A. I asked [the Port Alberni Police Officer], I believe where he got it, whether she sent it. They denied sending it to him, so –

Q. I see. So was that the end of that little dust up? Did it go further?

A. No. That was it. I directed him to [the regional coroner]. He wrote the letter - phoned [the regional coroner], wrote the letter and got a clean copy.

...

Q. ... you were obviously not happy with what happened there in terms of him phoning you and he having a copy of that report?

A. Well, I wasn't sure whether he actually had it or not. He could have just said it to –

Q. Is that what you thought at the time?

A. Crossed my mind.

Q. Did you say that to him?

A. No.

Q. What did you say to him?

A. Nothing. I told him that I wasn't going to release a copy to him. It wasn't my place to do that and he would have to speak to [the regional coroner], which he did, and she obviously asked him for a letter in writing as to the reason why, and she made the decision he is doing an investigation and we had a duty to release it, which it was.

MCFD District Supervisor asks for and receives final autopsy report from regional coroner

After speaking with the regional coroner, the MCFD District Supervisor faxed a letter to her dated the same day that read as follows:

> This letter is to advise you that the Child Protection Branch of the Ministry of Children & Family Development is involved in completing a Child Protection Investigation as mandated under Sec. 16 of the CFCS Act.
>
> We have concerns regarding any injuries to the above child and would appreciate receiving a copy of the Autopsy Report for our investigation.
>
> A consent is not required as the above factors have been assessed as reasons to believe the child may have been at risk of harm and determined to be reportable under Sec. 14 of the Child & Family Service Act [sic]. Please provide this information as soon as possible.

The regional coroner immediately faxed the final autopsy report to the district MCFD office. A mailed copy also arrived on April 1, with a cover letter stating that the contents of the final autopsy report were confidential, remained the property of the BC Coroners Service and must not be copied or disseminated. The first page of the final autopsy report bore a stamp to the same effect that was signed by the regional coroner.

Even though the MCFD District Supervisor had acquired a copy of the final autopsy report from the Coroners Service, he still thought it important enough to send the Regional Assistant Director the email that he had composed earlier in the day on March 27:

> [Regional Assistant Director], this note was going to go to you….but I tracked down the Regional Coroner and she will send me a copy….so you don't have to do anything. I didn't need a subpoena or anything…just a request.
>
> But in terms of how we may impact the Criminal aspect of this case…..are there pitfalls? **I didn't want to delete this note….so here it is anyway.**
>
> [Regional Assistant Director], we have only received a **copy** of the Coroner's report through the courtesy of the RCMP.
>
> We will be proceeding with a removal situation and have some concerns that if we do not receive our own, Original, Coroner's report there would be a possible "tainting" or perception, with the Criminal Investigation.
>
> We will be having to "disclose" our information to the court and it would be only appropriate that we have our own document.
> Does this sound reasonable? Or am I paranoid? The RCMP are disturbed with us doing much sharing of info as it may compromise their position.
>
> We have discussed this with [the Community Services Manager] and trust that we will not seriously impact the Criminal aspect of this case when we bring MCFD's interpretation of the events and risks.
>
> So please assist us in getting our own Coroner's Report and advise if we have any serious legal conflicts or steps to take.
>
> Timeliness is important as we may be going to court this week or early next week **(within 7 days)**

Disclosure an issue in district MCFD April 2 report to court

District MCFD's April 2 report to court described the circumstances of the removal of the caregivers' children as follows:

> A 20-month old girl, while in the care of [the caregivers], died on September 4, 2002 in their home. The death is consistent with battered child syndrome, as she suffered extensive abuse. RCMP investigation and timeline of incident suggests either parent may be involved. RCMP consider both parents suspects and potentially culpable in this death.
>
> MCFD is pursuing our investigation and consulting with RCMP. Considering the seriousness of this situation, MCFD has removed as certain protection requirements need to be implemented.

Counsel for the female caregiver promptly faxed a letter dated April 3 that objected to the adequacy of disclosure:

> I do not presume to tell the Director how to run the hearing at any time, but I do note my disclosure is woefully inadequate to date and, based on past experiences in this kind of situation, it is not very satisfying all around to have the social worker simply present unsubstantiated hearsay. It would be helpful to hear from RCMP witnesses and to have the medical reports as exhibits in order to better address the issues my client must meet in order to secure the return of the children to her.

Wrong impression results from Coroner's inquiry to police

Meanwhile, the Coroner had inquired and been told by the police that they had not in fact sent the final autopsy report to the MCFD District Supervisor. This created the unfortunate impression that the MCFD District Supervisor had attempted to obtain the final autopsy report by misrepresenting to the Coroner that he already had a marked copy from the police when he did not.

This incorrect impression about the MCFD District Supervisor was reinforced again a year later when the Coroners Service communicated, unconcernedly for its part, about the sharing of information on the child's injuries in this case. An April 22, 2004 email from the Coroners Service to MCFD headquarters attached a summary of the Coroner's actions and remarked: "From my perspective lines of communication appear to be quite good." An April 30, 2004 email from the Coroners Service to MCFD headquarters provided the following "clarification on some facts":

> 1. [The MCFD District Supervisor] was aware on September 12/02, that injuries were found at autopsy.
> 2. Given that this was a criminal investigation, the police did not want information released.
> 3. There were no details of the injuries provided until the October 31 conversations.
> 4. The Coroner can recall no contact with [the Deputy Director, Aboriginal Services].
> 5. The situation (ie: release of information) was further complicated by the fact that Usma case worker was the sister-in-law of the foster mother.

A final May 5, 2004 email from the Coroners Service to MCFD headquarters stated:

> ...RCMP indicated that at no time was [the MCFD District Supervisor] given a copy of the report as he has suggested.

[The MCFD District Supervisor] contacted [the Coroner] indicating he had the autopsy report from the RCMP and requesting a "clean copy". This request was denied.

The Port Alberni Police Officer assigned to the case informed this investigation that, until it was brought to her attention through the investigation, she had not in fact been aware that there was correspondence between the police and MCFD in which the police provided the district MCFD with a copy of the final autopsy report on March 12, 2003.

May 8: District MCFD does comprehensive risk assessment

District MCFD together with the Child Protection Consultant did a 16-page comprehensive risk assessment of the caregivers' children in relation to both the caregivers. It was completed on May 8 (signed May 9). All three children were assigned a high-risk rating. Extracts from the comprehensive risk assessment, although not entirely accurate in its narration of events, encapsulated the perspective of the district MCFD on what had happened since September and why the children were at high risk of harm:

> **Reason for CRA** - This Risk Assessment is being done as a result of intake 13 dated January 29, 2003.
>
> The Ministry initially became involved regarding [the child's] death on September 4, 2003 [sic]. See intake 12. [The child] had been living in the home with [the caregivers] under a section 8 agreement by NTC. She had been in the home for 3 weeks and was 21 months old at the time of her death. At that time MCFD did not find the remaining children to be in need of protection. [The child's] cause of death was unclear however both [the caregivers] stated that her 4-year-old brother…had pushed her down the stairs.
>
> [The female caregiver] stated she was out of the home at the time of the incident and [the male caregiver] was at home caring for [the child] at the time. [The male caregiver] stated he was upstairs watching T.V. and the children were playing in the stairwell. [The male caregiver] said he heard several thugs (*sic*) and he got up and found [the child] lying at the bottom of the stairs not moving. He called 911 and performed mouth to mouth, as she was not breathing. The Coroner felt the cause of death could not have been caused by falling down the stairs however the investigation did not find any other section 13 concerns. The intake was closed pending the autopsy report.
>
> On January 29, 2003 a new intake was opened as the autopsy report was shared with MCFD and indicated "battered child syndrome" as being the cause of death for [the child]. The report indicated multiple head injuries and abdominal injuries including fractured ribs that were 1-3 weeks old. The child sustained damage to her liver, kidney and heart as well.
>
> At the time of the investigation, [the female caregiver] had recently split with [the male caregiver] due to him being 'emotionally distant' and smoking dope. An agreement was made with [the female caregiver] that the children would reside with a relative while the investigation was ongoing. On February 24, 2003 [the female caregiver] moved into the relative's home. The children were removed March 27, 2003 after the HARC team reviewed the autopsy report. The children are currently in a relative foster placement. The presentation hearing has been adjourned to May 21, 2003. The RCMP investigation is ongoing.
>
> **Overall Risk Rating**
> The likelihood of future harm without intervention due to physical abuse is high. [The caregivers] had a dependent relationship plagued with domestic violence and continued

substance misuse. [The female caregiver] worked out of the home and left [the male caregiver] to care for the children. [The female caregiver] had expressed past concerns about [the male caregiver's] ability to care for the children and had been a victim of his violence and complained about his drug use but still left him to care for her 3 children and 2 relatives children. The severity of the injuries to the deceased child indicate a violent interaction with force. The child also had old injuries such as fractured ribs. Neither [the female nor the male caregiver] have offered an explanation for these injuries and both could have been culpable given the time frames of the injuries. A vulnerable young child died a violent death while in the care of either [the female or male caregiver]. The child was 'beaten to death'. Given that there is no explanation being given by either [the female or male caregiver] this necessarily places their own children at high risk of future harm.

June 13: Caregivers' children returned to female caregiver

After a contested hearing on June 4, the court made an order that the caregivers' children remain in the custody of the Director under the CFCSA. The children were then returned to the female caregiver, on MCFD's application, on June 13. By that time the male caregiver had been charged in the death of the child. He was being held in custody and the police wrote a letter clearing the female caregiver of suspicion. The reasons given in MCFD's report to the court were:

> The RCMP completed their investigation and have stated that [the female caregiver] is not a suspect in the death of [the child]. The death of [the child] occurred in the home of [the caregivers]. In light of the RCMP's conclusion that [the female caregiver] is not a suspect in the death of [the child], [the female caregiver's] children were subsequently returned.
>
> The mother, [the female caregiver], has agreed and signed the Risk Reduction Service Plan that involves counseling for her and the children. [The female caregiver] also accepts MCFD involvement in the completion of this plan.

PART 3: OBSERVATIONS AND ADVICE

The story of the continued placement of the brother and the caregivers' children in the Port Alberni home of the caregivers after the death of the child is a compelling one. Everyone who reads the story will take different things from it. What I take from it are three overriding themes:

- the importance of inter-agency communication of highly relevant protection information
- the importance of leadership from MCFD management (headquarters and regional) in supporting front-line protection workers; and
- the need for outside perspectives and expertise in making risk assessments when child homicide is a possibility.

While there is a place for individual accountability, in my view the greatest value of this kind of investigation is in what it teaches us about how things can go wrong and how the system could be redesigned to prevent things from going wrong in the future. Nonetheless, I do want to record my strong conviction that all of the officials involved with this case, within the limitations of their skills, knowledge and existing mindsets, acted in good faith in the course of fulfilling their responsibilities.

Fortunately, the worst potential outcomes of leaving the brother and the caregivers' children in the home after the child's death did not materialize. Nevertheless, a risk was taken that should not have been taken. Unacceptable risks do not always result in tragedy, and there is much to be learned from studying individual cases where risks are taken that do not have a tragic outcome.

3.1 Inter-Agency Communication of Highly Relevant Protection Information

Flawed inter-agency communications (including not sharing crucially relevant information) was the one feature that stood out above all others as a factor in the 35 child abuse fatality inquiries examined in *Beyond Blame: Child Abuse Tragedies Revisited*.[17] Digging more deeply into what lay behind the pattern of poor inter-agency communications, the authors (all three experienced in child protection work) found that at times the poor communications were caused by over-rigid boundaries (or perception of rigid boundaries) that prevented the exchange of information and co-operative planning.[18] It is my observation that this was a critical factor in this case.

The details of the child's injuries in the September 9 interim autopsy report indicated that the circumstances of her death and the male caregiver's account of her fall down a few steps were deeply suspicious. The Coroner[19] had the report on September 9, and the local RCMP officer assigned to the case knew the details of it on September 10. MCFD headquarters learned enough on September 10 to be able to describe the injuries in a September 11 briefing note to the MCFD executive. That briefing note also included as "key points" the fact that no cause of death had yet been determined, but that interim autopsy results indicated injuries not consistent with the explanation given by the male caregiver.

The Coroner recalled that he did not provide MCFD with details of the child's injuries (although the investigation found that he likely did), and that he had opposed release of information in the interim autopsy report to the child welfare system until the regional coroner directed him to provide Usma with information at the end of October (which he did by reading from the interim autopsy report over the telephone). By that time the district MCFD and Usma social workers were deeply confused about what they knew about the child's injuries, about the meaning of what they thought they knew, and about whether they could use information from the Coroner for child protection purposes. The October 31 telephone call with the Coroner ended up leaving Usma more confused than ever.

As it turned out, the final autopsy report was a long time coming, and then only became available to protection workers, with further delay and difficulty, in March 2003. It concluded that the cause of death was battered child syndrome. The fact is that the evidence upon which that finding was made was essentially all included in the interim autopsy report.

The RCMP have rightly acknowledged to this investigation their obligation under Section 14 of the CFCSA to report to child welfare authorities when they have reason to believe that a child needs protection.

The Coroners Service and the Coroner, on the other hand, have submitted that Section 14, while it is interesting and applies to anyone, is not relevant for them because a coroner's

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[17] Peter Reder, Sylvia Duncan and Moira Gray, *Beyond Blame: Child Abuse Tragedies Revisited* (London: Routledge, 1993).

[18] *Beyond Blame*, p. 82.

[19] Throughout this report, "the Coroner" is used to mean the local Port Alberni coroner. When the provincial coroner's operation is referred to, "the Coroners Service" is used.

authority relates only to the dead, not the living. It is disconcerting, to say the least, that the government organization charged with the responsibility of investigating deaths should adhere to a belief in such a rigid boundary between the coroner's responsibility to the dead child and the broader statutory responsibility (which the coroner shares with others) to the living children who remained in the home when the child died in suspicious circumstances.

This perspective – that the coroners' obligations are only to the dead, and apparently do not include a full sharing of highly relevant information about the dead child to ensure the safety of the living children who remained – in my view reflects a mindset or organizational culture that will not easily be changed, but which needs to be changed if the value of protecting living children is to be given the prominence that it deserves. An immediate focus of all officials involved in a death of this kind – when a child dies at home in suspicious circumstances and other children remain in the home – should be the protection of those remaining children, in addition to investigating potential criminal culpability for the death.

The RCMP have submitted that they believed they passed sufficient information to MCFD and Usma to alert them to the possibility that other children in the home might be at risk. This remains their firm belief now. The Coroners Service and the Coroner held and hold a similar perspective. Likewise, the protection workers involved believed and believe that, on the evidentiary likelihood of harm test that they are required to apply, they made the best sense they could of the "usable" information that was known to them.

I agree with the RCMP and the Coroner that waiting for the final autopsy report and concern about jeopardizing a future criminal investigation were serious considerations – but not just for the RCMP and the Coroner. They were serious considerations for the child welfare officials, too. And they were considerations that the child welfare officials were capable of understanding and having due respect for, in conjunction with their colleagues in the RCMP and the Coroners Service and in compliance with the confidentiality requirements in Section 16 of the CFCSA.

Society undoubtedly has an interest in the protection of the public by the investigation and prosecution of crime. Society has an equally important interest in protecting children from harm. These are not either/or propositions. We need to do both, and full exchange of information in this case would have assisted both the child protection and the child death investigations.

The Coroner apparently was concerned that the confidentiality of information passed to Usma might be compromised because the female caregiver and her sister-in-law were Usma employees. These concerns should not have been visited on the agency as a whole. They should have been clearly and directly raised with Usma and MCFD.

Communication is a two-way street. Managers in MCFD headquarters, including Aboriginal Services, were, or should have been, aware of MCFD's information-sharing memorandum of understanding with the Coroners Service, which provided for the supplying of MCFD with preliminary information about the cause of death by the local coroner. This was intended to cover interim autopsy information. They were also aware that there was an "issue" about communicating information from the Coroner to Usma. MCFD headquarters managers should have corrected the Coroner's ignorance of the information-sharing memorandum of understanding and resolved his concerns about information sharing with Usma.

Wherever the fault with inter-agency communications lay, and whatever MCFD and Usma could or should have deduced from what they were told about the child's injuries, the fact is that a cloud of uncertainty remained for six months around what was clear medical evidence of suspicious injuries. This uncertainty was an obstacle to a thorough assessment – that should have been done – of the risk of leaving children in the caregivers' home. The Coroner and MCFD headquarters and regional managers, all playing their own roles, could have done much more to ensure that the interim autopsy report was conveyed, accurately, to child welfare officials, and interpreted by a medical advisor for the benefit of the protection workers who were responsible for assessing the risk of harm to the children in the caregivers' home.

All the officials involved when a child dies in suspicious circumstances in a home where other children remain after their death should be sharing the relevant information they have to ensure a fully informed assessment of the risk of leaving the remaining children in that home. They also all need to be part of the intelligent assessment and management of confidentiality measures that may be required to prevent prejudice to a criminal investigation, instead of finding themselves catapulted into the wild informational misunderstandings that occurred in this case. The direct availability of informed medical advice about the ramifications of the circumstances of the death for the risk of harm to the living children is essential.

Had there been full and immediate sharing of the interim autopsy findings, and medical advice provided for protection workers about the meaning of that information, the children would almost certainly have been removed from the caregivers' home in September 2002.

No comfort should be taken that the kind of dismal inter-agency communication deficiencies that happened in this case cannot, and will not, happen again.

3.2 The Need for Leadership from MCFD Management

The people from MCFD headquarters and regional and district MCFD who were involved with the case all understood, at some level, that there was an "issue" about the Coroner being opposed to the sharing of information with Usma. Without exception, they thought withholding relevant information from Usma was improper and unfair to the Usma protection workers assigned to the case who had fully delegated child protection responsibilities to fulfill under the CFCSA. Despite this view, none of the managers at MCFD headquarters or within the regional MCFD operation took the leadership necessary to cut through any communications problems with the Coroner and to be assertive with the Coroner about his obligation to share the relevant information. With leadership within MCFD headquarters, the information sharing confusion that was snowballing within MCFD and affecting their relationship with Usma could have been cleared up. Instead, the responsibility for handling the information sharing "issue" with the Coroner fell to an Aboriginal Services Practice Analyst who, though he had experience as a field social worker, had no experience with the Coroners Service and no experience with a child death. Opportunities for clarification and intervention, such as the October 28 telephone call between the Usma Supervisor and the Deputy Director, Aboriginal Services were lost and there were no properly coordinated communications by MCFD headquarters, Aboriginal Services and regional MCFD to the district MCFD and Usma supervisors and protection workers about the information sharing "issue" or the details of the child's injuries.

Neither did managers at MCFD headquarters provide the needed leadership in supporting Usma in thoroughly assessing the risks of leaving the brother in the home. There was a view among some in Aboriginal Services that the continued placement of the brother in the home under a kith and kin agreement was questionable in the circumstances. Yet there was a reluctance to put this view clearly to Usma, and no steps were taken to offer Usma access to child abuse expertise. The reluctance to intervene appears to have been motivated largely by a perception that a hands-off approach by MCFD headquarters in case management was necessary to show respect for the autonomy of delegated Aboriginal agencies and to allow them to build confidence by managing on their own. In my view this is a misguided notion of respect and how to build confidence. The investigation heard from those at Usma that, while they wanted to understand the basis for intervention from MCFD headquarters into their case management decisions, they also wanted assistance in dealing with what for them was a new and unusual situation. It is true that in most cases, MCFD headquarters would not intervene, but this was on the face of it a case that was out of the ordinary, involving the sudden death of a child in unresolved circumstances, that Aboriginal Services must or should have known would not be within the usual Usma experience.

It is also true that on October 28 the Deputy Director, Aboriginal Services did express her view to the Usma Supervisor that a removal would be wise, and that she met with resistance and the anticipated annoyance about MCFD interference. But underlying that conversation was the reality that the Deputy Director, Aboriginal Services was not fully sharing with the Usma Supervisor everything she knew – not a good basis for developing trust.

There were times when those at MCFD headquarters who had more relevant and extensive experience in child protection, and were in a better position to communicate about a

problem with the Coroners Service or provide clear case management advice and direction, did not take charge because they perceived that it was not their job. While it may be strictly true that it did not fall within their job descriptions, such a rigid view of responsibility is not healthy from an organizational perspective. Whether their role as managers was to coordinate, to consult, to communicate information, to step in for someone who was away, to give advice, or to direct, these managers were involved in this case, and they were responsible for bringing to their involvement the fullness of their skill and knowledge and wisdom coming from their experience.

This broad approach to responsibility and leadership does not come easily in large bureaucracies. It needs to be nurtured but is more often than not discouraged. I am not suggesting that MCFD is unique in this respect. It is not common for government organizations to encourage leadership of this sort. However, the fact that in the case of MCFD the welfare of children is at stake and the fact that the key work of the ministry happens at the front lines compel a more flexible approach to management. It puts a premium on the creation of an organizational environment that encourages managers to respond to unusual circumstances when the interests of the individual child or children are at risk in a way that may not fit easily within their job descriptions and reporting relationships. In the same way that information sharing for protection purposes in the context of a possible criminal investigation requires a culture shift, it is likely that for this broad approach to responsibility to prevail within MCFD there will need to be a culture shift or change in mindset.

Another example of an organizational failure to encourage managerial leadership is reflected in the regional Assistant Director's view of his role when he received a call for help from the District Supervisor. The Assistant Director believed that he ought to be "distant, separate, and apart from the decision-making string in order to allow them [the regional director's office] to objectively review the case, given that that's part of their responsibility should they need to." This belief is troubling, especially if, as he told the investigation, the Assistant Director had been instructed in it by MCFD headquarters and it reflected an organizational view of the role of the director under the CFCSA.

Whether this view was what MCFD headquarters meant to convey or the Assistant Director misinterpreted the meaning of their instructions, the significant story here is one of undue concern within the organization about the procedural requirements of the director's review process and insufficient focus on supporting, in whatever way possible, those who were charged with the line responsibility for assessing the safety risk to the living children remaining in the home. Directors and deputy and assistant directors under the CFCSA are chosen for their specialized expertise in child protection and guardianship. Their expertise ought to be readily available to assist in the handling of difficult cases, even if there is someone else in the direct line of operational responsibility. If that creates problems in a subsequent administrative review, so be it. The priority should be the correct handling of current practice issues and not the need to remain detached just in case issues are raised in the future and a retrospective review is required.

This lack of organizational focus (except at the Usma and district MCFD level) on the issue of the risk to these children was further reflected in the fact that the concerns that Aboriginal Services staff had about the continued placement of the brother were mostly expressed in the context of other issues, such as the setting up of the director's case review process or the complexity of funding responsibility for the kith and kin agreement.

If more leadership had been taken in this case by MCFD managers, both at headquarters and the regional level, and had there been greater organizational focus on the need to

support the front-line workers in their tough decision-making in what was a very out-of-the-ordinary case for them, would that have made a difference? I believe so. Those with greater managerial authority and more experience could have overcome the communications issues with the Coroner to convey the complete medical information to the decision-makers, given clearer advice to help them make informed decisions, and facilitated their access to child abuse expertise.

3.3 Outside Perspectives and Expertise in Risk Assessments in Potential Child Homicide Cases

Another important theme in this story is the importance of bringing in outside perspective and expertise when assessing risk for remaining children in potential child homicide cases.

The authors of *Beyond Blame* point out that assessment has a central place in child protection work. They illustrate how problems with risk assessment influenced decisions in the child abuse fatality cases they looked at.[20] They identified four obstacles to a good assessment, all related to the information upon which a good assessment is based:

- unknown information
- known information that is not fully appreciated or correctly interpreted, possibly because of, among other things, a false sense of security, distrust of the information source, or inability to distinguish what is relevant or irrelevant
- information not fully assembled for one person to see enough to recognize its significance
- available information that does not fit current modes of understanding.[21]

In my observation, all of these obstacles to a good assessment were present in this case. I have already spoken about unknown information or information that was known by someone in the child protection authority but not fully assembled by the one or two persons who were charged in Usma and the district MCFD with the responsibility for making the assessment.

Usma and the district MCFD Supervisors and Protection Workers did, however, have significant and mounting evidence of risk to the brother and the caregivers' children if they remained in the home of the caregivers. In my view both Usma and district MCFD supervisors and protection workers had difficulty fully appreciating or correctly interpreting the information they did have, in part because it did not fit into their current modes of understanding or their overriding beliefs about the caregivers. This is not an uncommon phenomenon, and there were a number of reasons to anticipate that it might happen in this case. As the authors of *Beyond Blame* state, "Once a case becomes dominated by a fixed view, workers' selective attention is likely to distort their observations and any contradictory information becomes difficult to acknowledge."[22]

Both district MCFD and Usma workers were inexperienced in dealing with child battering cases leading to death. Again, this is not unusual. Child homicides are fortunately rare and the dynamic that results in fatal maltreatment is known to be quite different from the usual kind of maltreatment that protection workers face.[23] Perhaps because of their lack of experience, they too readily interpreted the information they did get about inconsistent injuries as referring to fractures that were incurred prior to the death and

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[20] *Beyond Blame*, p. 83.

[21] *Beyond Blame*, p. 84, citing R. Dingwall, "The Jasmine Beckford affair," Modern Law Review, 49 (1986), pp. 489–507.

[22] *Beyond Blame*, p. 92.

[23] D. Borget and J. Bradford, "Homicidal parents," *Canadian Journal of Psychiatry*, 35 (1990), pp. 233–238.

which they thought were likely a result of abuse by one or other of the child's parents. This could have been overcome had they been given full information about the injuries, interpreted by people with expertise in child abuse. Nevertheless, it was a view that became lodged in their minds and created an obstacle to fully appreciating the warning signs they were given.

No one with medical expertise ended up being consulted by the Usma or MCFD Supervisor or Protection Workers about the child's injuries until March 2003, when the district MCFD, who had independently obtained a copy of the final autopsy report from the police, and Usma met with physicians and a social worker from the Vancouver Island Health Assessment and Resources for Children (HARC) unit.[24] Given that the information about the injuries in the interim autopsy report was essentially the same as in the final report, there is every reason to believe that an early consultation with medical experts, Child Protection Consultants and HARC would have resulted in a more rigorous assessment of risk and an earlier removal of the children.

Aside from the medical information from the autopsy, information was available in the paper files of the past intakes related to the caregivers about a history of domestic violence and violence on the part of the male caregiver toward children. The MCFD district supervisor read this material; the Usma supervisor did not. Whether because of a lack of information or of understanding about the significance of that information, those responsible for assessing the situation gave inadequate weight to this history and its current impact, including the likelihood that the female caregiver would not reveal to either family members or the Usma Supervisor or Protection Workers the fullness of the male caregiver's violent behaviour.

The district MCFD Protection Worker was candid with the investigation when he reflected on his thinking as he made the immediate safety assessment. He acknowledged that it could have gone two ways: he could have adopted either the sinister or the family tragedy explanation. In the context of positive things being said about the female caregiver, he chose to put a lot of weight on the family tragedy explanation. Revealingly, he said, "I mean the other thought is horrific."

It certainly would have been (and ultimately was) horrific for the Usma workers who had facilitated the placement of the child and her brother in the caregivers' home to realize that the sinister explanation was the correct one. Based on what they knew and could understand at the time, they had reason to maintain their view that the protection threat came exclusively from the parents, not the caregivers. All the same, it was a fixed view that dominated their thinking and was difficult to dislodge with evidence that suggested the contrary.

With respect to the Usma Director who had supervisory responsibility in this case in the first two weeks after the child's death, there was the added factor of her kinship relationships with the caregivers, the child and the brother. The Usma Director made it very clear to the investigation that she did not believe that these relationships brought with them additional inside information, or affected her handling of the case. Nevertheless, it inevitably would have made it that much more difficult to arrive at a conclusion that the brother was unsafe in the caregivers' home because the death of his sister was caused by the abuse by one of the caregivers.

The kinship relationships of the Usma Director with the caregivers should not be surprising

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[24] Vancouver Island's Suspected Child Abuse and Neglect team.

in the context of Aboriginal agencies serving small Aboriginal communities where almost everyone is related. It is a strength of delegated Aboriginal agencies that they have roots in the communities they serve. It increases the level of trust with community members, in contrast to the high level of distrust of non-Aboriginal child welfare authorities brought about by a long history for First Nations communities of having their children taken away from their communities, to the long-term detriment of both the children and the communities.

As is often the case, what is in one set of circumstances a strength, in another can be a weakness or at least something that needs to be acknowledged and planned for so that it does not get in the way of good delivery of child welfare services. The reality of close ties of Aboriginal agency workers with the families and communities they serve is not a reason not to give Aboriginal agencies child welfare authority, but it is a reason to make sure that in unusual circumstances such as this, these agencies are fully supported by outside resources that can bring fresh eyes to the situation and apply expert knowledge that will reveal a pattern different from the one that is seen from a close perspective.

3.4 Immediate Response and Multi-Agency Child Death Teams

There are several recommendations that could flow from this account of the continued placement of the children in the caregivers' home after the child's death. I am limiting myself to a single recommendation, in part to emphasize its centrality to promoting best practices in such situations, and in part because I expect that all the agencies involved – the Coroners Service, the RCMP, MCFD and Usma – will make reasonable adjustments to their own practices and inter-agency communications protocols as a result of what they learn from reading this report.

Recommendation

I strongly urge the government to implement a system of multi-agency child death teams to provide an immediate response when:
(a) a child dies unexpectedly in the home or care of a caregiver,
(b) the circumstances of the death are unexplained, and
(c) other children remain in the home or care of the dead child's caregiver.

There is an important difference between a multi-agency child death team that responds immediately to the death and a multidisciplinary team that engages in the retrospective review of child deaths.

A retrospective review of child deaths takes place after criminal, coroner, and in some cases, like MCFD's director's case review, internal investigations and reviews are completed. The retrospective review usually builds on the case information gathered by these other investigations and reviews. The primary purpose of a retrospective review is to learn from what happened and make recommendations to prevent the same thing from happening again in the future. There may also be a monitoring or public accountability function.

The Children's Commission, in fulfilling its mandate to do retrospective child death reviews, established a multidisciplinary team to assist in reviewing individual cases. The mandate of the new Representative for Children and Youth, like that of the Children's Commission, is to conduct retrospective critical injury and child death reviews. The *Representative for Children and Youth Act* expressly prohibits the Representative from investigating a critical injury or child death until after the completion of criminal investigations and criminal court proceedings and other investigations (such as MCFD's director's case review process). In the case of a non-criminal investigation, the Representative may start his or her investigation one year after the death, even if the other investigation is not complete. In his report, *BC Children and Youth Review* (2006), Ted Hughes recommends that the new Representative for Children and Youth establish a multidisciplinary team to provide advice and guidance regarding individual reviews and assist in the analysis of aggregated injury and death information.

An immediate response by a multi-agency child death team is a relatively new concept that is different from a multidisciplinary team engaged in a retrospective review of deaths. It is being used in some American states, such as California and Michigan, not as a monitoring tool, but as an alternative way to respond to suspicious child death investigations.

With multi-agency child death teams, the core team includes representatives from the coroner, the police, prosecuting lawyers, child protection authorities, pediatricians with child abuse expertise, and health professionals, including public health nurses. The team responds at the local level immediately after the death. Police, child protection workers, coroners and public health nursing team members all conduct home visits and investigations. Their investigations sometimes lead to criminal proceedings. (Michigan's child death teams involved in immediate response have identified a number of child abuse deaths that were initially thought to be accidental or natural deaths.) The focus of the teams is on the detection, management and prevention of fatal child abuse. They look only at deaths with suspicious causation that are selected through an established protocol. Because many of the resources for the team's activities come from the member agencies, specific funding for the teams is limited.

Multi-agency teams that respond immediately to a suspicious child death are in other jurisdictions usually referred to as "child death review teams." Some of them combine the retrospective review function with the immediate collaborative response and investigation function. I have dropped the word "review" in describing the team I am recommending for British Columbia, so that its function will not be confused with the child death review function mandated for the Representative in the *Representative for Children and Youth Act*. That does not mean that a multi-agency child death team could not engage in systemic review as one of its activities. Indeed, one of the advantages to an multi-agency response team approach is the opportunity it provides for reflection on how to improve inter-agency communications and how individual agencies can improve their own systems.

The article "Origins and Clinical Relevance of Child Death Review Teams"[25] outlines the advantages of a multi-agency team response to child deaths. They include:

All teams save costs through increased effectiveness of interventions and reduced duplication of efforts.

> ...The multi-agency team process is more vigorous than a single agency process, more capable of clearly identifying a case that is suspicious, and more able to deal with special challenges, such as the difficulty of identifying the perpetrator out of multiple caretakers, separating out physical findings that confuse the determination of cause of death, or distinguishing sudden infant death syndrome from suffocation. The results are more focused, more complete, and the process is more accountable.
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> ...Child death review also creates an opportunity for a systematic review of agency actions (and inactions). This has been particularly important with respect to improving and integrating interagency communications, and allowing agencies the opportunity to address deficits in their own systems.

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[25] Michael K. Durfee, George A. Gellert, and Deanne Tilton Durfee, "Origins and Clinical Relevance of Child Death Review Teams," *Children Today* 21:2, 29–33.

> ...Health professionals with previous contact with the child or family can improve their clinical judgment and case management skills by learning retrospectively from the follow-up information obtained through child death review.
>
> ...Team education allows...professionals to become a resource for detecting and referring medical and social problems that predispose a family to violence.[26]

In the *Report on the Core Services Review of the Children's Commission and Overlapping Services Provided by Other Agencies* (2001), I recommended that an in-depth feasibility assessment be done of the use of a multi-agency child death team approach in British Columbia to the investigation of suspicious children's deaths. As far as I know, no feasibility assessment of the approach has been conducted.

The results of this investigation bring into stark relief the need for such an immediate, collaborative response to child deaths of this kind. In this case, it would have made all the difference if the Coroner, the RCMP, Usma and MCFD had fully and immediately shared available information, and in conjunction with child abuse experts such as HARC, critically and collectively assessed the circumstances of the death. The risk to the children would have been understood in a timely way, and the police might well have been assisted in planning for and initiating a more prompt criminal investigation.

It is not good enough to read about what happened in this case and say that what we need are better communications. As *Beyond Blame* has shown, flawed inter-agency communications are endemic in systems. They do not go away by simply exposing them in an individual case and blaming the individuals involved when something goes wrong. They are often rooted in the culture of organizations. The only way to make a change is to commit to a different systemic approach, one that demands collaboration and sharing of information.

There will undoubtedly be those who resist a system of multi-agency teams to immediately respond to suspicious child deaths. Changing organizational cultures and entrenched ways of doing things is never easy, but it can be done, as witnessed in the American states that have adopted this approach. While some organizational resistance can be expected, the concept should be pursued.

My recommendation in this report goes beyond suggesting that a feasibility assessment be conducted. I advise the government to commit itself to pursuing this multi-agency approach and move ahead on it now. Public policy initiatives are often motivated by public reaction to an individual case. The death of the Nuu-chah-nulth child in 2002 has triggered many significant public policy recommendations. This report is unique in that the focus has been not on the causes of a child's death, but on the interests of the living children. The children were not, to our knowledge, physically harmed while they remained in the home, but they were left for too many months in circumstances with an unacceptable risk of harm. The establishment of a system of immediate-response multi-agency child death teams would be a first in Canada, and an enduring legacy to the Nuu-chah-nulth child who died and her living brother.

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[26] "Origins and Clinical Relevance," p. 32

APPENDIX A:

Draft Practice Guideline for Section 8 ("Kith and Kin") Agreements (MCFD, 2002)

July 2002 DRAFT

Practice Guideline for Section 8 Agreements

Introduction:

This document sets out the Ministry's expectations for using a Section 8 Agreement in order to provide protection to children in accordance with the principle of least disruptive measures. The document is intended for the use of child protection workers.

Under section 8 of the Child, Family and Community Service Act, a director may make a written agreement with a person who has established a relationship with a child or has a cultural or traditional responsibility toward a child, and is given care of the child by the child's parent. The agreement may provide for the director to contribute to the child's support while the child is in the person's care.

The intent of section 8 is:

- To increase the capacity of families and communities to provide the least disruptive response to child protection concerns
- To recognize the capacity of parents to find alternate care arrangements when their child has been deemed to be in need of protection
- To give parents whose child(ren) is in need of protection the means to develop a plan for their child(ren) instead of being removed by MCFD
- To allow child protection workers to make an agreement with a child's kin or significant person chosen by the family to care for a child

The key point with section 8 agreements is that the parent has met parental responsibilities by making alternate care arrangements for the child, and by doing so, removes the need for more disruptive intervention by the ministry. The agreement for the child's care is between the parent and care providers. Unless there are known protection concerns with the care providers, the ministry has no requirement to intervene and take more disruptive action.

Section 8 agreements do not replace the Ministry of Human Resources' Children In Home of a Relative Program (CIHR). The CIHR program is available to provide financial support to relatives subject to a means test to care for children who are not considered to be in need of protection.

The implementation of section 8 supports the Ministry's strategic shift from protecting children through removal towards promoting family and community capacity to protect children while supporting children and family development.

Deciding When To Use Section 8 Agreements

A section 8 agreement can be used in the following situations:

A. When a determination has been made under risk decision 4, or practice standard 17 for Aboriginal Agencies, that a child is in need of protection. Section 8 agreements are part of the continuum of least disruptive measures and are less disruptive than removing children from their families via voluntary care agreements or court orders. Section 8 agreements are considered as a least disruptive measure for children deemed to be at risk as long as adherence to agreements will eliminate/reduce the identified risk.

B. When considering returning a child who is in care under an interim or temporary order and:

- you and the parents are able to agree about how to protect the child using a section 8 agreement
- extended family or others who were not available prior to the removal of the child are now willing and able to care for the child
- you assess that there is no need for supervision, or the parent and the alternate care provider consent to an order of supervision
- the section 8 criteria outlined below are met

Note1: Using section 8 agreements following removal although possible, is not recommended as sections 35(2)(d) and 41(1)(b) can be used in these circumstances.
Note 2: When considering using a section 8 agreement following removal, consult with legal counsel about determining the best way of terminating the existing order, placing the child back with the parent(s), and making the section 8 agreement in order to avoid placing the child at risk.

In addition to the above, the criteria for using a section 8 agreement include:

- agreement by the parent(s) that the child is at risk
- the availability of people who are willing and able to care responsibly for the child.
- a determination that the identified risk can be eliminated or reduced to a safe level by the child residing with a family chosen by his/her parents
- a determination that contact between the child and his/her parents does not constitute a risk to the child's safety and well-being
- a willingness by the parents and the new care provider to work cooperatively with the ministry/Aboriginal Agency
- a willingness and ability of the parents and the new care provider to enter into an agreement
- an understanding by the parents that the new care provider must be advised of the identified risk to the child and the reason for ministry's/Aboriginal Agency's initial and on-going involvement

Preparing for a Section 8 Agreement:

- A section 8 agreement is part of the risk reduction service plan. The risk reduction service plan should identify how the section 8 agreement is expected to adequately reduce the risk to the child.
- A signed copy of the agreement between the ministry/Aboriginal Agency and the new care provider(s) should be attached to the risk reduction service plan.
- The family service file will be designated as a child protection file, and the practice standards for child protection will apply. Note: For Aboriginal Agencies the file will be considered a child protection file and will be designated in accordance with the classification system.
- Your on-going involvement will be to monitor the situation to ensure the plan for the child is being followed and to assist the family in order to reduce/eliminate the identified risks to the child.

Involving the child:

Ensure as much as possible in accordance with the child's age and development, that the child understands the reason(s) for and the nature of the agreement. If the child is over age 12, the child should consent to the agreement. If the child is between ages 6 and 11, the child's views about the agreement must be taken into consideration. If a child refuses to agree to reside with the new care provider(s), other means of protecting the child should be considered based upon least disruptive measures and the child's best interests. Under a section 8 agreement, the child is not in the ministry's care or under court ordered supervision

Involving the parent(s):

The child's parent(s) remain responsible for ensuring that adequate care arrangements are made for their child(ren). The responsibilities of the parent(s) include:

- exploring all reasonable and available options within the family and family support system that will meet the child's needs
- choosing a responsible family member or friend who has a significant relationship with the child who can best care for the child and ensure his/her safety.
- entering into an agreement with the potential care provider that outlines each party's responsibilities and obligations
- working with the ministry to reduce identified risks to the child so that the child can return home safely in a timely manner
- advise the ministry of any significant changes in their circumstances that will affect the child and/or care provider(s)

Involving the care provider(s):

A) Assessment Process:

You should:

- conduct a prior contact check regarding the care provider(s)
- conduct a criminal record check – please refer to appendices for acceptance criteria
- obtain two letters of reference from relatives

Note: A formal assessment of the care providers will not be conducted. The pre-agreement checks are intended to ensure that there are no known child protection concerns/issues with the care providers.

If you are uncertain about whether to accept the alternate care provider as a placement for the child based upon the information arising from the pre-agreement checks:

- discuss your concerns with the care providers in order to obtain their views and/or explanation
- discuss your concerns with the child's family with the permission of the care providers in order to determine their views
- discuss the pertinent information in consultation with your supervisor

The acceptance test is based upon whether any of the circumstances outlined in section 13 are present. The care provider should not be accepted if any of these circumstances apply.

B) Roles:

The role of the care provider selected by the family is to:

- enter into an agreement with the family that outlines each party's responsibilities and obligations in caring for the child (for a copy of the agreement, please refer to appendices)
- enter into an agreement with the ministry outlining responsibilities of each party and if necessary, financial support (for a copy of this agreement form, please refer to appendices)
- work cooperatively with the ministry regarding the safety and well-being of the child throughout the duration of the agreement

C) Financial Support:

Advise care provider that:

- interim financial support up to $450.00 for each child per month is available from the ministry Note: the amount of the financial support may change in September
- he/she may be eligible to receive the federal Child Tax Benefit and the provincial Family Bonus.

- she/he should contact Canada Customs and Revenue Canada to apply for the federal Child Tax Benefit.

Aboriginal children:

In keeping with the following principles of the Child, Family and Community Service Act,

- the cultural identity of aboriginal children should be preserved
- aboriginal people should be involved in the planning and delivery of services to aboriginal families and their children
- if the child is an aboriginal child, the importance of preserving the child's cultural identity must be considered in determining the child's best interests

The services provided to the child and family throughout a section 8 agreement should be culturally appropriate

Note:
It is important that the child, the child's family and the new care provider understand that the child is not in the care of the ministry.
The child's band should be notified by the parents of the child's placement with the new care provider.

(Section 8 agreements are a significant way by which aboriginal children can continue to be cared for by family members. Discussion regarding the availability of financial support in order to assist with the implementation is on-going with MCFD.)

(Needs: more input from Aboriginal Services/community)

Agreement between Parent and Care Provider:

You do not sign this agreement but should be involved to:

- Recommend that both parties seek independent legal advice prior to signing an agreement.
- Discuss with the parent and care provider significant issues relating to caring for the child to ensure that the care provider is fully informed and recommend that the issues are included in the agreement.
  - issues include: consent to necessary health care; consent to routine recreational/school activities; medical coverage remains with the parent(s)
- Ensure that the parent(s) understand that they will not receive the federal Child Tax Benefit or the provincial Family Bonus while the child is with the care provider
- Advise both parties that they can use the agreement form if they wish or write one of their own. (please refer to the appendices for a sample)
- Advise both parties that this agreement must be signed before the ministry can complete a section 8 agreement with the care provider.

Entering into a Section 8 Agreement

When entering into a section 8 agreement, you should:

- Recommend to the care providers that they seek independent legal advice prior to signing an agreement.

- Ensure that the care provider(s) understand that:
  - the MCFD agreement form is not prescribed.
  - medical and optical coverage will be provided by MCFD. Dental coverage will be decided upon a case by case basis.
  - the care provider should contact Canada Customs and Revenue Canada to apply for the Children's Special Allowance
  - they need to advise you of any changes or anticipated changes that affect the care of the child(ren)

- Review the signed agreement between the parents and care provider to ensure that guardianship responsibilities have been transferred.

- Review the terms and conditions outlined in the agreement between the care provider and the ministry.

- Ensure that the time limits for the agreement is consistent with section 6, Voluntary Care Agreements:
  - the initial term of the agreement must not exceed
    (a) 3 months, if the child is under 5 years of age on the date the agreement is signed, or
    (b) 6 months, in any other case

  - The agreement may be renewed, but the total duration of the agreement and all renewals must not exceed, from the date the first agreement was signed,
    (a) 12 months, if the child or the youngest child who is the subject of the agreement was under 5 years of age on that date,
    (b) 18 months, if the child or the youngest child who is the subject of the agreement was 5 years of age or over but under 12 years of age on that date, or
    (c) 24 months, if the child or the youngest child who is the subject of the agreement was 12 years of age or over on that date.
- Exceptions to these time lines should be approved by Regional Executive Directors or designate.

- Sign the agreement and distribute:
  - keep the original for your office/region financial services
    - the service line for financial support for the care providers is 14309
  - give a copy to the care provider
  - attach a copy to the risk reduction service plan and place in the protective family service file

Monitoring, Reviewing and Renewing a Section 8 Agreement:

When monitoring and reviewing a section 8 agreement, you should:

- monitor the situation to ensure that the plan for the child is being followed.
  Note: You are not monitoring the care providers' home or care of the child.
- ensure that you and/or the care provider inform the parent's about significant events relating to the child's care.
- ensure that the parents are aware of their responsibility to keep themselves informed of their child's day to day care.
- arrange regular scheduled reviews of the agreements to ensure the plan still meets the child's needs. This review may also be at the request of parent, care provider, and/or child.
- review the risk reduction service plan prior to the expiration of the agreement in accordance with practice standard 28 and risk decision 7 or standard 26 for Aboriginal Agencies.
- you may renew an agreement with the care provider as long as the criteria for using a section 8 agreement are met. Agreements should not last longer than is absolutely necessary.

Terminating an Agreement:

You may terminate an agreement by giving at least 7 days written notice to the care provider when:
- the care provider is not complying with the agreement
- the care provider decides that she/he is not able or willing to meet the terms and conditions of the agreement

The agreement will terminate:
- if the parent(s) retake care of the child(ren) prior to end date of the agreement
- the term of the agreement has expired.

When considering returning the child(ren) to his/her family, and/or to close the family file, risk decisions 8 and 9 must be completed. For Aboriginal Agencies standard 26 must be completed.

If the child cannot return safely to his/her parents and an extension of the section 8 agreement is not an option, the child protection worker will discuss other ways of protecting the child in accordance with the least disruptive measures.

If the agreement is about to expire, and you feel that the child cannot return home safely, write a letter to care providers advising them of the status of the risk reduction plan and of their obligation to advise you if the child does return home.

Appendix A

Criminal Record Check Acceptance Criteria

Criminal record checks conducted by MCFD cover all ministry and contracted staff providing services to children and adults. These checks relate to all offences including all crimes against persons, property crimes, fraud, impaired/dangerous driving, robbery, weapons and possession of drugs. The information accessed is:

- CPIC
- Local police files
- Informal police information

The Criminal Record Review Act (CRRA) is designed to help prevent the physical and sexual abuse of children by requiring individuals who work directly with children to undergo criminal record checks. The act includes a schedule of offences that are deemed to be significant for a person working with children. As the focus of the CRRA is on persons who work with children, it does not apply to section 8 care providers. As a result, ministry workers must obtain a criminal record check on potential section 8 care providers using the CPIC data base but should use the CRRA's schedule of offences as a basis for deciding whether a child should be placed with the care providers.

The CRRA's schedule of offences:

- Section 151: Sexual Interference
- Section 152: Invitation to Sexual Touching
- Section 153: Sexual Exploitation
- Section 155: Incest
- Section 159: Anal intercourse
- Section 160: Bestiality
- Section 161: Order of prohibition
- Section163.1: Child Pornography
- Section 170: Parent or Guardian Procuring Sexual Activity
- Section 171: Householder Permitting Sexual Activity
- Section 172: Corrupting Children
- Section 173(1): Indecent Acts
- Section 173(2): Exposure
- Section 177: Trespassing at Night
- Section 179: Vagrancy
- Section 212(1): Procuring a Person for the Purposes of Prostitution
- Section 212(2): Living Off Avails of Child Prostitution
- Section 212(4): Attempting to Obtain the Sexual Services of a Child
- Section 215: Duties of Persons to Provide Necessities
- Section 218: Abandoning Child
- Section 220: Causing Death by Criminal Negligence
- Section 221: Causing Bodily Harm by Criminal Negligence
- Section 229: Murder
- Section 235: Punishment for Murder
- Section 236: Punishment for Manslaughter
- Section 237: Punishment for Infanticide
- Section 4: Trafficking

When conducting a criminal record check the presence of these offences signal that caution must be used in deciding whether to enter into a section 8 agreement. The presence of these offences should be considered according to the risk posed to the child based upon the following information.

Risk determination:

When determining whether the person with a criminal record presents a risk to the safety of a child consider:

- the relevance of the particular criminal activity to the care and conduct with the child
- whether the behaviour associated with the relevant offence would if repeated, pose a threat to the safety and well-being of the child
- the circumstances of the offence including the age of the individual at the time of the offence and the existence of any extenuating circumstances
- any other relevant factor including the elapsed time since the occurrence of the offence or alleged offence, subsequent actions of the individual, the likelihood of the individual repeating a similar kind of behaviour and any attempts at rehabilitation.
- the number of charges, convictions and diversions
- the developmental age of the child, the child's circumstances, and the nature of the child's existing relationship with the person

Note: New charges relating to these offences that occur during the placement of a child should be assessed in the same manner as the initial outstanding charges and convictions.

An acquittal of any of the above charges should be considered along with relevant information (if any) obtained from a previous Ministry contact check.

Appendix B – Agreement Between Ministry and Careprovider

CHILD FAMILY AND COMMUNITY SERVICE ACT
SECTION 8 AGREEMENT

This Agreement dated for reference the _____day of _____20_____

Between

_____
(The "Caregiver(s)")

And

The Director, Child Family and Community Service Act, designated by the Minister for Region_____
(The "Director")

The Caregiver(s) have been given care of the following child(ren) by the child(ren)'s Parent(s):_____

_____, born_____ , gender:_____

_____, born_____ , gender:_____

_____, born_____ , gender:_____

_____, born_____ , gender:_____

Promises and Statements of the Caregiver(s)

1. I/we will:

   (a) Assume responsibility for the care, parenting and nurturing of the Child(ren);
   (b) With the funds provided by the Director under the terms of this Agreement, pay the costs associated with caring for the Child(ren) including food, transportation, personal needs, recreation, clothing, children's allowance, gifts, activities, and educational components;
   (c) Co-operate with any access orders or agreements relating to the child(ren);
   (d) Notify the Director immediately if the parent(s) retake care of the child(ren);
   (e) Notify the Director as soon as possible of any change in the Caregiver(s)' family composition or ability to provide care for the Child(ren).

Promises and Statements of the Director

2. The Director:

   (a) Will designate a social worker to have contact with the child(ren) to facilitate the risk reduction plan;
   (b) Will provide the Caregiver with all the information available to the director relevant for the care of the child, including but not limited to

the medical, educational and personal care information and any guardianship, custody access arrangements;

(c) Will pay the Caregiver up to $450.00 per month for each child, or such higher amount as may be set by ministry policy from time to time, to be applied as described in paragraph 1(b) of this Agreement

(d) Will provide premium Medical Service Plan coverage for the child(ren)

(e) Will provide optical coverage for the child(ren) on the same basis and terms as is provided to children in restricted foster care

(f) Will provide dental coverage for the child(ren) on a case by case basis.

Miscellaneous

3. The Director and Caregiver agree:

(a) It is the responsibility of the Caregiver(s) to determine whether the payments received from the Director are taxable under the Income Tax Act (Canada);

(b) It is the responsibility of the Caregiver(s) to comply with workers compensation legislation and other applicable legislation;

(c) Regardless of the date of execution or delivery of this Agreement, the term of this Agreement starts on _____and ends on _____;

(d) This Agreement will end if the parent(s)retake care of the child(ren), after the expiration of 7 days notice, given by either the Director or Caregiver(s) that this Agreement will end, or the term of the Agreement has expired;

(e) Any notice to be given under this Agreement, to be affective, must be in writing and delivered personally, by courier or prepaid registered mail to the following addresses:

Address for notices to the
Director_____

Address for notices to the
Caregiver(s)_____

Note: The Caregiver should contact Canada Customs and Revenue Canada to apply for the Child Tax Benefit

The parties have executed this Agreement as follows:

Signed on behalf of the
Director by an authorised representative

_____Date:_____
Signature of Authorised Representative

_____
Printed name of Authorised Representative

Signed by the Caregiver(s)

_____Date:_____
Signature of the Caregiver(s)

_____

Printed name of the Caregiver(s)

Appendix C – Sample of a Section 8 Agreement Between Parent(s) and Care Providers

Agreement with Child's Kin and Others

This agreement dated for reference this _____day of _____, 20___.

BETWEEN _____
(the "Parent(s)")

AND _____
(the "Caregiver(s)")

RECITALS

A. The Parent(s) have custody of the following child(ren):

_____, born _____, gender _____

_____, born _____, gender _____

_____, born _____, gender _____

B. The Caregiver(s) have agreed to care for the children.

C. The Parent(s) and Caregiver(s) agree that "care" means physical care and control of the children.

D. The Parent(s) and Caregiver(s) agree that either party may provide a copy of this agreement to a director, designated under the Child Family and Community Service Act.

Promises and Statements of the Parent(s)

I/we:

1. Transfer care of the child(ren) to the Caregiver(s) for the period of time commencing on _____ and ending on_____;

2. Authorize the Caregiver(s) to consent to the child(ren)'s participation in routine school and recreational activities, in addition to exercising care and control over the child(ren);

3. Will maintain frequent contact with the child(ren) while the child(ren) is/are in the care of the Caregiver(s).

4. _____

_____

_____

_____

(Additional terms may be added)

Promises and Statements of the Caregiver(s)

I/we:

1. Agree to assume responsibility for the care, parenting and nurturing of the children;

2. Acknowledge that the Parent(s) may retake care of the child(ren) at any time;

3. Will co-operate with any access orders or agreements related to the child(ren);

4. Will notify the Parent(s) of any change in the Caregiver(s) household composition or ability to care for t child(ren);

5. Will notify the Parent(s) immediately if the child(ren) becomes ill or suffers any serious injury.

6. _____

_____

_____

_____

_____

(Additional terms may be added)

The Parties have executed this agreement as follows:

Signed by the Parent(s)

_____ _____
Date signed

_____

_____
Address of Parents

_____
Telephone number of Parents

Signed by the Caregiver (s)

_____ _____
Date signed

_____

_____
Address of Caregiver(s)

_____
Telephone number of Caregiver(s)

APPENDIX B:

MCF Practice Standards for Child Protection (in Place in 2002/03)

Practice Standard 1: Protocols

You must follow all protocols for child protection and information sharing with police, education, health, and other agencies and organizations.

Practice Standard 2: Children from aboriginal communities

You must establish whether a child is from an aboriginal community. If so, you must involve the appropriate community in assessment, investigation and case planning according to local protocols.

Practice Standard 3: Cultural, racial & religious differences

Child protection practice must be carried out in a climate of understanding and respect for a family's cultural background, race and religious beliefs.

Practice Standard 4: Reportable circumstances

You must report to the Director within 24 hours in the following circumstances:

- the death or critical injury of a child in care or a child who has received services in the last 12 months
- serious incidents involving a child in care, including the child's exposure to high-risk or life-threatening circumstances, involvement in crimes of violence, or abuse or neglect while in care.

Practice Standard 5: Case records

You must ensure that files and case records are:

- kept in the form required, whether in electronic format or on paper;
- kept confidential
- maintained in a secure location at all times.

Practice Standard 6: Supervisory responsibility

You must consult with your supervisor and have your supervisor approve your decisions at the following points in a protection case:

At any point
- where a reportable circumstance occurs
- where you must notify police
- where you are considering the use of court

Intake
- RD #1: Deciding whether to investigate a report

Investigation
- RD #2; Determining the response time to a report
- when developing an initial investigation plan
- RD #3: Assessing the child's immediate safety and developing an immediate safety plan
- RD #4: Deciding if the child needs protection
- where the investigation cannot be completed within 30 days

Risk Assessment
- RD #5: Assessing the risk of future abuse and neglect

Risk Reduction
- RD #6: Developing a risk reduction service plan
- where you are considering removing a child/bringing a child into care

Ongoing Protective Family Service
- RD #7: Re-assessing risk
- RD #8: Re-unifying a family
- RD #9: Transferring or closing a case
- Reclassifying a case from protective family service to voluntary family service

Practice Standard 7: Assessment of reports

You must assess every report you receive about a child's need for protection.

Practice Standard 8: Prior contact check and registration

When you receive a child protection report, you must complete a prior contact check and register the intake.

Practice Standard 9: Determining the speed of assessment

You must assess the report immediately if:

- the child appears to be in a life-threatening or dangerous situation
- the police have reported that the child has killed, assaulted or endangered another person
- the police have taken charge and have not been authorized to return the child to the parent or a designated person.

In all other cases, the report must be assessed within 24 hours.

Practice Standard 10: Risk Decision #1: Deciding whether to investigate

When you receive a report about a child's need for protection, you must make Risk Decision #1 to determine whether to investigate.

In the case of a third protection report about a young child within one year, you must always investigate.

Practice Standard 11: Informing the police

In all cases or physical abuse, sexual abuse, or sexual exploitation, you must:

- provide the details of the report to the police
- ask the police for information on any criminal activities of all members of the household.

Practice Standard 12: Risk Decision #2: Determining the investigation response time

The investigation must start as soon as possible and

- immediately if the child appears in a life-threatening or dangerous situation
- within five calendar days in all other cases.

Practice Standard 13: Initial plan of investigation

Before starting an investigation, you must create an initial plan for how the investigation will proceed.

Practice Standard 14: Steps required to complete the investigation

In all child protection investigations, you must:

- see and interview the child
- see and interview all other children in the household
- see and interview the parents/caregivers
- interview the alleged offender (where police are involved, consult with them before contacting the alleged offender)
- interview any other witnesses
- directly observe the child's living situation
- obtain any relevant reports about the child and family
- obtain information and reports from collaterals who may have relevant information about the child and family
- review relevant past records and files
- in cases of medical neglect, contact the family physician or other medical practitioner who has recently treated the child
- where required, take the child for a medical examination
- interview any other people who may have relevant information about the child and family.

Practice Standard 15: Seeing and interviewing the child

The child who is subject of a protection investigation must be seen:

- immediately if the child is in a life threatening or dangerous situation
- as soon as possible in all other situations.

Practice Standard 16: Arranging a medical examination of the child

In all cases where you suspect that the child has been physically abused, sexually abused or seriously neglected, you must arrange for the child to be medically examined.

Practice Standard 17: Seeing and interviewing the parent

In all child protection investigations, you must see and interview the parent(s) in person.

Practice Standard 18: Risk Decision #3: Assessing the child's immediate safety

You must complete an Immediate Safety Assessment for each child as soon as you have sufficient information.

In cases where a child's immediate situation has been assessed as "unsafe", you must develop an Immediate Safety Plan.

Practice Standard 19: Risk Decision #4: Deciding whether the child needs protection

In every investigation, you must make Risk Decision #4 about whether the child needs protection.

Practice Standard 20: Investigative action where you cannot locate the child or family

In an investigation where you cannot locate the child or family, you must:

- make every reasonable effort to locate the child or family and complete the investigation
- place an alert on the CIS.

Practice Standard 21: Recording and reporting the investigation results

On concluding the investigation, you must record the results and report the outcomes to:

- the parent apparently entitled to custody
- the person who made the report
- the child, if the child is capable of understanding the information

unless

- reporting the result would cause physical or emotional harm to anyone or endanger the child's safety; or
- a criminal investigation into the matter is underway or contemplated.

In reporting the results of the investigation, you must protect the identity of the reporter.

Practice Standard 22: Time limit for investigations

You must complete the investigation within 30 days.

If circumstances make it impossible for you to meet this standard, you must produce a plan for completion and have it approved by your supervisor.

Practice Standard 23: Risk Decision #5: Assessing the risk of future abuse and neglect

You must complete a comprehensive risk assessment whenever you have found that a child needs protection.

Practice Standard 24: Risk assessment of a third report

You must complete a comprehensive risk assessment whenever you receive a third child protection report about a young child within one year.

Practice Standard 25: Risk Decision #6: Developing a risk reduction service plan

Once you have completed a comprehensive risk assessment, you must develop a Risk Reduction Service Plan to reduce the highest risk factors, in consultation with the child, the family and others who will have a role in the plan.

Practice Standard 26: Supervision orders

In all cases, a supervision order must include the following terms and conditions:

- that you have direct and private access to the child and the child's home
- that you will remove the child if you are denied direct and private access according to the terms of the supervision order.

You must also advise the court which terms and conditions will result in the child's removal in the case of non-compliance.

Practice Standard 27: Removing a child

You must remove a child without a court order if:

- you believe an existing supervision order no longer protects the child
- a person breaches a term or condition of a supervision order and the court has ordered that the child be removed if a person breaches a term or a condition.

Practice Standard 28: Risk Decisions #7, 8, 9: Reassessing risk

You must complete a comprehensive risk assessment with your supervisor and review the risk reduction service plan:

- during regular case reviews (every 4 months)
- at significant changes or proposed changes in family circumstances or composition
- before transferring or closing a case
- when a third child protection report is received within one year
- before a child returns home
- before the expiration of a supervision order.

Practice Standard 29: Reclassifying a child from protective to voluntary family case

Where a re-assessment of risk, done in consultation with your supervisor, indicates that the risk factors identified in the risk assessment have been resolved, and the child is no longer in need of protection, the case may be reclassified as a voluntary family service case.

Practice Standard 30: Where a child or family is missing

If a child who is in care or a child or family with an open Protective Family Service file is missing, lost or runaway, you must:

- place an alert on the CIS
- make ongoing reasonable efforts to locate the child or family.

Practice Standard 31: Transferring a protective family service case

Before transferring a protective family service case, you must complete a risk assessment and service plan review, obtain your supervisor's approval and reach agreement with the receiving staff about:

- the need for the transfer
- the timing of the transfer
- the process for the transfer

Before transferring the case, you must arrange for a full briefing of information with the receiving staff and the timely transfer of all material and information to the receiving staff.

Practice Standard 32: Closing a protective family service case

Before closing a protective family service case, you must:

- have your supervisor's approval
- complete a risk re-assessment and review the risk reduction service plan
- meet with the child and family to discuss the closure
- notify service providers that the file will be closed.

APPENDIX C:

Aboriginal Operational and Practice Standards and Indicators ("AOPSI"), Level 15 Practice Standards

Standard 1: Protocol with MCF and Ancillary Agencies

The social worker follows all protocols for child protection and information sharing with police, education, health, and other agencies and organizations.

Standard 2: Cultural, Racial and Religious Differences

The social worker carries out child protection practice in a climate of understanding and respect for the family's cultural background, race, and religious beliefs.

Standard 3: Reportable Circumstances

The Executive Director/Program Director of the Agency and the Director of Child, and Family Services are notified of reportable circumstances.

Standard 4: Supervisor Responsibility

The social worker obtains approval of the supervisor at key points in a protection case.

Standard 5: Initial Response to Reports

The social worker receives reports and clarifies expectations regarding information-sharing with the reporter.

Standard 6: Prior Contact Check and Registration

When the social worker receives a child protection report, he or she completes a prior contact check and registers the intake.

Standard 7: Assessment and Emergency Response

An assessment of every report is made and the response time is appropriate.

Standard 8: Deciding Whether to Investigate

After assessing the report, the social worker determines whether to investigate. In the case of a third protection report within one year about a young child (i.e. under five), the social worker always investigates.

Standard 9: Informing the Police

In all cases of physical abuse, sexual abuse, or sexual exploitation, the social worker provides the details of the report to the police, and asks the police for information on any criminal activities regarding all members of the household.

Standard 10: Determining the Investigation Response Time

The social worker begins the investigation as soon as possible, and:

- Immediately, if the child appears to be a life-threatening or dangerous situation;
- Within five calendar days in all other cases.

Standard 11: Initial Plan of Investigation

Before starting an investigation, the social worker creates an initial plan for how the investigation will proceed.

Standard 12: Steps in the Investigation

The social worker completes the required steps in the investigation in order to develop a thorough and accurate assessment of the child's need for protection.

The social worker gives priority to seeing the child and ensuring the child's immediate safety.

Standard 13: Seeing and Interviewing the Child

The child who is the subject of a child protection investigation is seen:

- Immediately, if the child is in a life threatening or dangerous situation
- as soon as possible in all other situations.

Standard 14: Arranging a Medical Examination of the Child

In all cases where the social worker has reason to believe that a child may have been physically abused, or seriously neglected, the social worker must arrange for the child to be examined by a medical practitioner. If the social worker has reason to believe that a child may have been sexually abused, the social worker arranges a medical examination, unless there are exceptional circumstances, in which case the social worker consults with the supervisor to determine if a medical examination is necessary.

Standard 15: Seeing and Interviewing the Parent

In all child protection investigations, the social worker must see and interview the parent(s) in person.

Standard 16: Assessing the Child's Immediate Safety

During the course of a child protection investigation, the social worker completes an Immediate Safety Assessment for each child who is the subject of the report as soon as the social worker has sufficient information to do so.

In cases where the child's immediate situation has been assessed as "unsafe", the social worker must develop an Immediate Safety Plan.

Standard 17: Deciding whether the Child Needs Protection

In every child protection investigation, the social worker must decide whether the child needs protection.

Standard 18: Action When the Child or Parent Cannot be Located

When the child or family cannot be located during the course of a child protection investigation, the social worker makes every reasonable effort to locate the child or family and complete the investigation.

The social worker places an alert on the Community Information System (C.IS.).

Standard 19: Recording and Reporting the Investigation Results

The social worker records the results of the investigation and reports the outcome to:

- the parent apparently entitled to custody;
- the person who made the report;
- the child, if the child is capable of understanding the information, unless:

a) reporting the result would cause physical or emotional harm to anyone or endanger the child's safety; or
b) a criminal investigation into the matter is underway or contemplated.

The social worker protects the identity of the reporter.

Standard 20: Time Limit for Investigations

The child protection investigation is completed within 30 days of receipt of the report.

Standard 21: Taking Charge

The social worker takes charge of a child when it is necessary to provide temporary care in the absence of a parent.

Standard 22: Risk Assessment

The social worker completes a comprehensive risk assessment, including cultural considerations, whenever the social worker has found that a child needs protection, and whenever a social worker receives a third child protection report about a young child within one year.

Standard 23: Risk Reduction

Once a comprehensive risk assessment has been completed, the social worker develops a risk reduction service plan to reduce the highest risk factors. This is done in consultation with the child, the family, and others who will have a role in the plan.

Standard 24: Supervision Orders

The social worker ensures all supervision orders include the following terms and conditions:

- that the social worker has direct and private access to the child and the child's home;

- that the social worker will remove the child if the social worker is denied direct and private access according to the terms of the supervision order.

The social worker advises the court which terms and conditions will result in the child's removal in the case of non-compliance.

Standard 25:Removing a Child Who is Subject to a Supervision Order

The social worker removes a child who is subject to a supervision order if:

- an existing supervision order no longer protects the child:
- a person breaches the terms or conditions of the order, that places the child at risk; and
- the court has ordered the child be removed if a person breaches a term or condition.

Standard 26: Reassessing Risk

The social worker completes a comprehensive risk assessment with the supervisor and reviews the risk reduction service plan:

- during regular case reviews (every 4 months);
- at significant changes or proposed changes in family circumstances or composition;
- before transferring or closing a case;
- when a third child protection report is received within one year;
- before the child returns home;
- before the expiration of a supervision order.

Standard 27: Where a Child or Family is Missing

If a child who is in care or a child and family with an open Protective Family Service file is missing, lost or runaway, the social worker

- places an alert in the CIS; and
- makes ongoing reasonable efforts to locate the child or family.

Standard 28: Transferring a Family Service Case

Before transferring a family service case, the social worker completes a service plan review, obtains the supervisor's approval, and reaches an agreement with the receiving staff about:

- the need for the transfer;
- the timing of the transfer;

- the process for the transfer.

A risk assessment is not required if the file has no protection issues and is instead a file opened as a result of a request for services.

Before transferring the case, the social worker arranges for a full briefing of information with the receiving staff, and the timely transfer of all material and information to the receiving staff.

Standard 29: Closing a Family Service Case

Before closing a family service case, the social worker:

- obtains the Agency supervisor's approval:
- reviews the risk reduction service plan;
- meets with child and family to discuss the closure of the file;
- notifies service providers that the file will be closed.

A risk assessment is not required if the file has no protection issues and is instead a file opened as a result of a request for services.

Standard 30: Investigating Allegations of Abuse in Family Care Homes

The social worker follows the protocol between the MCF and the B.C. Federation of Foster Parents Association with respect to the investigation of allegations of abuse in family care homes, when conducting an investigation involving a family care home.

APPENDIX D:

July 31 2002 Memorandum re Addressing "Likelihood" Child Protection Concerns

BRITISH COLUMBIA

Ministry of Children and Family Development

Child and Family Development Division

MEMORANDUM

Ref: 112598

Date: July 31, 2002

To: Interim Chief Executive Officers

Regional Executive Directors

Community Service Managers

Re: Practice Memoranda Involving Child Protection Practice Standards Procedure

The Child and Family Development Division, as a result of consultation with regional staff, has developed the following four practice memoranda. The practice memoranda describe policy shifts to empower local decision-making to protect children in the communities where they reside, whenever possible.

The four areas of practice include:

1. Addressing "Likelihood" Protection Concerns
2. Responding to Child Protection Reports Involving Youth
3. Clarification of Risk Decision 4
4. New Direction for practice with regard to the Rule of the Third Report and the Re-Assessment of Risk

The attached memoranda outline procedures that provide greater flexibility to respond to child protection matters.

The practice memos will be placed on the ministry Intranet web-site under Manuals/Child and Family Development/Child Protection Memos. The link is:

http://icw.mcf.gov.bc.ca/manuals/man_cfd_policy.htm#cp_memos

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Staff who require information about these practice memoranda are to consult with their supervisor, child protection consultant or appropriate community service manager. If further consultation is required, please contact the Protecting Children in their Community Unit, Child and Family Development Division, at 250 387-5213.

Thank you.

David W. Young
Assistant Deputy Minister
Child and Family Development Division

Attachments (4)

pc: Elaine Murray
Assistant Deputy Minister
Regional Operations

Jeremy Berland
Executive Director
Services to Aboriginal Children and Families

Child and Family Development Division Directors

Child and Family Development Division Managers

fc: Assistant Deputy Minister's Dayfile
Protecting Children in their Community Unit

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Date: July 31, 2002

Ref: 112599

CP#: 02-03

To: Interim Chief Executive Officers

Regional Executive Directors

Elaine Murray
Assistant Deputy Minister
Regional Operations

Jeremy Berland
Executive Director
Services to Aboriginal Children and Families

Re: Addressing "Likelihood" Child Protection Concerns

Historically in order for child protection workers to intervene to protect children on a non-voluntary basis, the children had to be victims of child maltreatment. Child protection workers could not intervene to protect children who were believed to be at risk of harm in the future even when the harm was likely.

In order to provide child protection workers with the authority they required to give children the protection they needed, the concept of future abuse or the likelihood of abuse has been addressed in most provincial child welfare legislation. This proactive stance of protecting children from becoming abused and harmed was introduced in the *Child, Family and Community Service Act* (*CFCSA*) in the following subsections of Section 13:

Section 13(1):

(a) if the child has been, or is likely to be, physically harmed by the child's parent
(b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent
(c) if the child has been, or is likely to be physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child
(d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent

.../2

The inclusion of the likelihood concept and wording in the CFCSA is crucial to enable child protection workers to carry out their responsibility to protect children. However, in order to be useful, "likelihood" must be interpreted in a practical manner. Please note below the likelihood interpretation points:

"Likelihood" is addressed in the:

- CFCSA
- Practice Standards for Child Protection – Standards 10, 12 and 19
- Risk Assessment Model – Risk Decisions 1, 2, 4

For practice purposes the definition of likelihood in the above mentioned practice standards and corresponding risk decisions should be interpreted by using a "balance of probabilities" test – the same test used by family court judges to determine a finding of a child in need of protection. Likelihood should be interpreted to mean that based upon professional judgement, it is more probable than not that an event/situation will occur. Likelihood should not be interpreted to mean a slight chance or possibility that an event/situation will occur.

- For Practice Standard 10 and Risk Decision 1 - When a child protection worker receives a child protection report that is based upon the likelihood of a child being harmed:

    - In accordance with Practice Standard 10, the child protection worker must have reasonable grounds supporting the probability that harm will occur based upon the information included in the child protection report, prior contact checks and other assessment sources carried out under Section 16 in order to conduct an investigation

    - If the child protection worker believes that a child is less than likely to be harmed after assessing the information, the child protection worker under Section 16 of the CFCSA may:

        - offer support services to the child and family
        - refer the child and family to a community agency
        - take no further action

- For Practice Standard 12 and Risk Decision 2 - The likelihood situations will remain a Priority 4 response for investigation unless there is information in the report that leads the child protection to believe harm is imminent

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- For Practice Standard 19 and Risk Decision 4 - If the child protection worker believes based upon information from an investigation, that it is more likely than not that a child needs protection the child protection worker must complete a comprehensive risk assessment and ensure the safety of the child by developing a risk reduction service plan based upon the least disruptive measures.

    - If the child protection worker believes that it is less than likely that a child needs protection, the child protection worker may:

        - Offer and/or provide voluntary family services
        - Take no further action

Conclusion:

- For practice purposes, "likelihood" should be interpreted by child protection workers to mean that there is reason to believe based upon known information that a child is more likely than not to be harmed.

- Although the Risk Assessment Model response Priority 4 includes many categories that involve the likelihood of harm, each situation must be assessed individually in order to determine the appropriate priority and level of response.

- Likelihood does not refer to the existence of risk but to the probability of risk that a child is likely to be harmed.

One family court judge visualized a balance of probability in this manner:

Continuum of Belief

0% belief		100% belief
%10	%51	%98
reason to believe (Section 14)	balance of probability	beyond reasonable doubt (Criminal court test)

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Changes in Responding to Likelihood Child Protection Reports:

Currently, once a likelihood report is received and assessed, a determination is made about a response. If the decision is made to investigate, the reports are assigned a Priority 4 response according to the risk assessment model. In many of these situations, one or two contacts will resolve the concern making a Practice Standard 14 investigation unnecessary and intrusive for the identified child and family.

Frequently in likelihood reports, an incident resulting in harm to a child has not occurred and as a result, factual information contained in these reports may be less substantive than in other child protection reports where harmful incidents have occurred. Because of the less substantive nature of the likelihood reports, a more extensive assessment in keeping with Section 16 of the CFCSA may assist in clarifying the concern and determining the most appropriate response.

Differential Response:

This means that child protection workers can now provide a differential or alternate response to child protection reports involving likelihood by deciding to extend the assessment process in accordance with Section 16 of the CFCSA. Through assessment, workers determine whether to offer support services, conduct an investigation or close the case.

Extending the assessment process can include:

- contacting the parent(s) in order to clarify the concerns
- contacting the child who is the subject of the report to clarify concerns
- with the parent(s) consent, contacting anyone else who may have information

Criteria:

The decision about whether to continue to assess the situation or to investigate should be based upon the factors associated with imminent safety and wellbeing of the child. Factors include:

- the age of the child
- vulnerability of the child
- the exposure of the child to the potential source of harm
- the severity/degree of the potential harm to the child
- the immediateness of the potential harm to the child
- previous child protection concerns relating to the child or to a sibling
- other factors such as family history, drug or alcohol issues, mental health issues, lack of support systems, environmental issues

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Further Information:

For further information on responding to "likelihood" protection concerns, consult with your supervisor, child protection consultant or your regional manager. If further consultation is required, please contact the Protecting Children in their Community Unit, Child and Family Development Division at 250 387-5213.

David W. Young
Assistant Deputy Minister
Child and Family Development Division

Pc: Brenda Huculak
Training Advisor
Education Services Branch

Possible Outcomes:

Extending the assessment process will assist in determining the best response that includes:

- providing voluntary services
- referring the family to a community agency
- conducting an investigation

Examples of likelihood reports that require an investigation include:

- situations wherein a child has been previously harmed and the presence of similar factors indicate a probability of recurrence
- a child whose sibling has been abused by a parent or caregiver and the parent/caregiver is caring for the child identified in the report
- a child who is being cared for by a known child abuser

Time Frame:

The time frame for completing and documenting the extensive assessment is five days.

Conclusion:

Child protection workers can provide a differential response to likelihood child protection reports by conducting an extensive assessment in order to clarify the nature and degree of concern. In many situations, these contacts will resolve the issue so that an investigation will not be necessary in keeping with the principle of least disruptive measures. The decision to investigate will be determined by considering the child's(ren) safety and wellbeing.

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fc: ADM's day file
Protecting Children in their Community

CFDDIV: ANDERSON: dk

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